UNIVERSITY OF ALBERTA

CLIENTS' PERCEPTIONS OF THE FOUR ROLES OF THE PROFESSIONAL NURSE IN A HEALTH PROMOTIVE SETTING

BY

SHELLEY MURRAY-BANNISTER ©

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of **MASTER OF NURSING.**

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ABSTRACT

The purpose of this study was to examine clients' perceptions of nurses' caring in a health promotive setting. The study was conducted using the methods of ethnography and ethnoscience. The sources of the data were interviews with five participants from a health promotion setting attached to a large urban hospital. The findings of this study led to identification of cooperative-collaborative, partnership relationships between clients and professional nurses as the necessary foundation for enactment of the following four roles: (1) Caring, (2), Health Promoting/ Health Advocacy, (3) Collaborating/ Client Advocating, and (4) Health Resource/ Communicating. Descriptions of the four roles begin to inform us of what professional nurses are doing when they are engaged in health promotion activities. Findings of this study are suggestive of the professional nurse being recognized by "going beyond", establishment of cooperative-collaborative relationships, and the way in which the client feels more powerful and in control as a result of interactions with the nurse. This study suggests that establishing cooperative-collaborative relationships between clients and nurses in health promotion, is a significant client-nurse interaction factor related to effective role enactment and client health outcomes.

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TABLE OF CONTENTS

Chapter		Page
I.	Introduction	1
	The Context	1
	Purpose and Rationale	3
II.	Literature Review	4
	Theories of Caring	5
	Variables Affecting Caring	11
	Perceptions of Caring	12
	Outcomes of Caring	15
	Settings	16
	Summary	17
	Research Question	17
III.	Methods	18
	Research Techniques	19
	Data Analysis	21
	Reliability and Validity	23
	Sampling	24
	General Issues of Reliability and Validity	27
	Ethical Issues	28
IV.	Findings	29
	The Concept of Professional	29
	Roles of a Professional Nurse in a Health Promotion Setting	32
	Caring Role	33
	Health Promoting/ Health Advocating Role	39
	Collaborating/ Client Advocating Role	42
	Communicating/ Health Resource Role	46
	Themes	53
V.	Discussion	56
	Critique of the Findings	56
	Historical Review	57
	Biomedical Approach	57
	PsychoBehavioral Approach	58
	Socioenvironmental Approach	59
	Health Promotion Models	59
	Discussion of the Findings	64
	Caring Role	64
	Health Promoting/ Health Advocating Role	67
	Collaborating/ Client Advocating Role	69
	Health Resource/ Communicating Role	71
	Themes	72
	Critique of the Methods	75
	Methods	75

Techniques ____ 77
Interviewing ____ 77
Sample ____ 78
Implications ____ 79
Future Research ____ 79
Nursing Practice ____ 80
Investigator's Practice ____ 81
Nursing Education ____ 83
Summary of the Study ____ 84

References ____ 87
Appendix A: Semantic Relationship/Domain Worksheet ____ 98
Appendix B: Advertisement for Volunteer Subjects ____ 99
Appendix C: Letter of Initial Contact ____ 100
Appendix D: Consent Form ____ 101
Appendix E: Consent Form for Validation Informant ____ 103
Appendix F: Informant Information Letter ____ 105

LIST OF TABLES

Table	Description	Page
1	Biographical Characteristics of the Informants	19

LIST OF FIGURES

Figure		Page
1	Taxonomy of the kinds of roles of a professional nurse in a health promotive setting	33

CHAPTER 1

Introduction

Caring is ubiquitous to the human experience. In fact, it has been suggested that caring is as fundamental and essential to health and well-being, as it is to growth (Gaylin, 1976; Paternoster, 1988). Though the nursing literature abounds with illustrations of, and references to caring, it has only been during the last 20 years that nursing researchers have begun a systematic investigation into the description, definition, and dimensions of caring. Well known are Chinn's (1991) observations that the knowledge concerning caring and the investigative methods required to address caring have been historically unexamined as areas of serious academic concern (p. xv). Yet, caring is intrinsic to nursing practice. An adequate theoretical and practical understanding of caring eludes us; at present, no universal definition of caring exists in nursing literature.

The Context

Enhanced technology and application of scientific knowledge has significantly contributed to the construction of the highly technical illness-focused, hospital-based system of cure, not care, which exists today. Escalating health care costs, changing professional and public values, and recognition that health is influenced by a broad range of factors (human biology, lifestyle, the organization of health care delivery, and the social, cultural, and physical environments in which individuals live) have led to dramatic changes in the delivery and financing of health care services in the 1990s. The current focus is one of health promotive activities rather than disease treatment. Clearly, a reorganization of health care delivery systems with health promotion as a central

component, is the present vision (Alberta Association of Registered Nurses, 1989; Alberta Health, 1993; Alberta Hospital Association & Health Unit Association of Alberta, 1987; Epp, 1986; Federal, Provincial, and Advisory Committee on Population Health, 1994; Larsen, 1991; Rachlis & Kushner, 1995). Such a shift from disease treatment to health promotion has placed new demands on nurses to understand what nurse caring is to clients in the context of health promotion and to provide care which is sensitive and meaningful to those receiving it.

As noted by Valentine (1988) and Paternoster (1988), the client's perception of caring is of primary importance, for caring is not what the care provider defines it as but rather what the care receiver perceives it to be. Health care providers must understand nurse caring from the client perspective, particularly in light of research suggesting a positive relationship between clients experiencing positive health outcomes, in combination with experiencing nurse caring behaviors (Duffy, 1992; Rieman, 1986a, 1986b).

Numerous authors identify the context specific nature of caring, and the need to determine if caring varies between settings, and whether clients perceive caring as being related to health and wellness outcomes (Benner, 1984; Benner & Wrubel, 1989; Jennings, 1991; Leininger, 1988a; Paternoster, 1988; Roberts, 1990; Valentine, 1988, Watson, 1985). The majority of nursing research on caring has been performed within an acute care environment. In defining nurse caring in a health promotive setting, it would seem essential that we know what clients perceive as caring, and seek to document and enhance those qualities. In a variety of studies completed to date, investigators report that clients place greater importance on instrumental aspects of nurse caring (monitoring and

giving treatments on time), while nurses define caring behaviors in the affective domain (listening and talking), as most important (Larson, 1987; Mayer, 1986; Rosenthal, 1992; von Essen and Sjoden, 1991a, 199b). Existing literature, though informative, has not addressed one important dimension of caring currently in need of explication: clients' perceptions of caring when the traditional encounter with nurses (resulting from an acute disease episode) is not their primary exposure to nurses' caring. In fact, no studies were located which investigated nurse caring as perceived by clients in a health promotive setting. This study seeks to explore this issue.

Purpose and Rationale

The purpose of this study was to gain an understanding of clients' perceptions of nurses' caring in a health promotive context. The findings may assist with the understanding of nurses' caring and its role in the provision of health promotive nursing care which results in positive health outcomes for clients.

CHAPTER II

Literature Review

The importance of the concept of caring in nursing is perhaps reflected by the nature and number of references to it. Historically, caring has been pervasive in the language of nursing since Florence Nightingale's writings during the 1800s. Though a lack of agreement as to the common use of the term still exists, the past 20 years mark a significant effort by a number of theorists who see caring as a phenomenon worthy of study (Leininger, 1988a; Roach, 1992; Warren, 1988; Watson, 1979). Nonetheless, there are gaps in our understanding and questions about the relationship between what is known about caring and how it can be utilized to guide nursing practice. One area neglected in nursing research is the investigation of clients' perceptions of nurse caring in settings other than acute care environments. The purpose of this review was to examine existing research, to demonstrate the rationale for this study, and to assist in determining the specific question to frame the inquiry. The extant literature on caring was primarily located within nursing, although the influence of theorists from philosophy and psychology, was made apparent through cross-referencing. Interestingly, the period which marks the dramatic increase in the number of nurses studying caring immediately follows the contributions of philosophers, to the area of caring. Secondly, the three bodies of literature generally differ in that philosophers view caring as a relational based fundamental part of our humanity, while psychologists see caring as the ethical nature of our relationships, and nurses have generally viewed caring as the essence or core of nursing, encompassing both humanity and an ethical way of being.

An analysis of the literature follows. Relevant literature was analyzed in terms of context, content, assumptions, biases, and methodology. The chapter concludes with a summary of the status of the literature and identification of significant gaps.

Theories of Caring

A dominant theory of caring does not exist. Within philosophy, many writers (among them, Buber, 1970; Heidegger, 1977; Marcel, 1969; and Mayerhoff, 1971), suggest that caring is fundamental to human existence. While Heidegger views caring as a universal phenomenon that is basic to being in the world, Buber, Marcel, and Mayerhoff discuss the relationship nature of caring. The fundamental thrust of their work is two-fold: the need to be in relationship with another in order for caring to occur, and the need to view others as subjects rather than objects. Buber describes this in greater detail as I-Thou relationships versus I-It relationships. Mayerhoff suggests that caring is a way of relating to others which assists them to grow and develop. Certain ingredients of caring, described by Mayerhoff (1971), which assist in this growth are: knowing, alternating rhythm, patience, honesty, hope, courage, and humility (p. 13-28). The contributions of psychologists May (1969) and Gaylin (1976) also suggest the relationship nature of caring, with Gaylin attesting to the critical nature of caring in terms of human development and survival. Both Gilligan (1982,1988), and Noddings (1984), two proponents of feminist thinking, address the ethical nature of caring. Gilligan suggests that caring is relational, as do the philosophers, but argues that as humans we have two modes of moral judgment: that of justice and that of care. Gilligan believes that as individuals we focus more heavily on one orientation or the other, with females more

likely to focus on the care orientation than the justice orientation. Noddings suggests that caring in practice, which is rooted in natural caring, is an ethical way of being in relationships with others.

Within nursing, diverse theories exist. Nursing theorists have identified caring as: the central unifying domain for the body of knowledge and practices in nursing (Leininger, 1988b); the essence of nursing and what makes nursing humanistic (Watson, 1988a); the human mode of being (Roach, 1992); and risking being with someone towards a moment of joy (Parse, 1988). Such philosophical conceptualizations of caring, however, have been criticized as being metaphorical and abstract (Gaut, 1983; Morse, Solberg, Neander, Bottorff, & Johnson, 1990).

Leininger, (1981) regarded by many as a leader in the advancement of caring within nursing, is perhaps best known for her ethnographic work on the transcultural aspects of caring. She (Leininger, 1988b) defines caring as those "actions directed toward assisting, supporting, or enabling another individual (or group) with evident or anticipated needs to ameliorate or improve a human condition or life way" (p. 156). She developed a taxonomy of 28 caring constructs:

comfort	compassion	concern
coping behaviors	empathy	health consultative acts
facilitating	interest	health instruction acts
involvement	helping behaviors	health maintenance acts
love	nurturance	presence
protective behaviors	restorative behaviors	sharing
stimulating behaviors	sharing	stress alleviation
succorance	support	surveillance
tenderness	touching,	trust, and others

(Leininger, 1981)

She encourages further development of caring from a transcultural perspective, using qualitative methods to further explicate caring as the essence of nursing. Leininger (1988a) asserts that what nurses do to provide care differs from culture to culture. Leininger's (1988b) early findings, that care is essential for human survival, growth, and development, supports Roach's thesis of caring as a human mode of being.

Roach (1992), noticeably influenced by Heidegger, believes that to care is part of being human, and the source of our caring is our humanity. She describes the attributes of professional nurse caring as compassion, competence, confidence, conscience, and commitment. These attributes are expressed in specific concrete nursing actions, which Roach suggests are neither exhaustive or exclusive. Roach suggests these 5Cs constitute a broad framework that encompasses categories of human behaviors for the expression of professional nursing. Roach (1984), like Watson (1985), stresses the importance of authentic presence and connectedness with others as a foundation to caring.

Watson (1979) describes nursing as being the human science of caring as it encompasses both scientific and humanistic dimensions. Watson has identified ten carative factors which form the foundation of transpersonal caring relationships and influence health and wellness outcomes. The ten carative factors are:

(1) The formation of a humanistic-altruistic system of values
(2) Instillation of faith-hope
(3) Cultivation of sensitivity to self and others,
(4) Development of a helping trust relationship
(5) Promotion and acceptance of the expression of positive and negative feelings
(6) Systematic use of the scientific problem solving method for decision making
(7) Promotion of interpersonal teaching and learning
(8) Provision of a supportive, protective, and(or) corrective mental, physical, sociocultural, and spiritual environment

(9) Assistance with the gratification of human needs
(10) Allowance for existential phenomenological forces (p. 9-10)

Watson believes that within a science of caring, one seeks to understand how health and illness concerns relate to human behavior, and how human behavior influences health and illness outcomes. She believes the human to human exchange in transpersonal caring relationships has the potential to influence healing, and encourages further ongoing research.

Parse (1988) argues that healing emerges through caring as well, resulting from the occurrence of connectedness between the nurse and the patient, when moments of joy are experienced in a relationship which is authentic and open. Parse relates the process of being and becoming as a result of the connectedness, which suggests that she has been influenced by Mayerhoff's (1971) work.

Following a review of relevant nursing literature, Morse, Solberg, Neander, Bottorff, and Johnson (1990) have noted these multiple conceptualizations of caring to fall into five major categories: (a) caring as a human trait, (b) caring as a moral imperative, (c) caring as an affect, (d) caring as an interpersonal process, and (e) caring as a nursing intervention. Others identify its use as a noun, a verb, an adjective, and an adverb (Komorita, Doehring, & Hirchert, 1991). Such uncertainty in answering the basic question, what is nurse caring, has led to difficulties in designing research that will contribute to our understanding of the phenomenon. Examination of the nursing literature on caring reveals that although a common theory of nurse caring does not exist, investigators have attempted to identify both behaviors and meanings of nurse caring by

focusing their efforts primarily on investigating perceptions of caring. Warren (1988) reviewed the nursing literature, and cites Henry (1975) as the first investigator, of many, who attempted to determine what nurse caring is and what meaning it holds for those experiencing it.

Prior to 1960, nursing investigators described caring for patients as the provision of food, cleanliness, and other such activities. Caring was viewed as a one way relationship in which the nurse provided for the patient's needs. Since the 1960s, nursing investigators have described "caring for" in the sense of providing for, apart from any sense of "caring about". However, they indicate "caring about" the other (in the sense of a valued other) brings a quality to the relationship between the carer and the cared for (Orlando, 1961; Travelbee, 1966). It is suggested that this evolution of the concept of caring, sometimes described as "helping relationships", eliminates the apathy, manipulation, and objectivity found in one way relationships of "caring for". Theorists have further developed this idea of caring as having two dimensions; instrumental (examples are: knows procedures, assists with pain management, and does assessments) and affective (examples are: shares, listens, and expresses hope) (Benner, 1984; Brown, 1986; Gaut, 1983; Griffin, 1983; Larson, 1987; Watson, 1979). Investigators have attempted to validate these theoretical views of caring (Cronin & Harrison, 1988; Lemmer, 1991).

In a notable work by Boykin and Schoenhofer (1990), the authors utilized five categories of questions to provide a framework for examining the contributions of scholars whose works have focused on caring in nursing: (a) ontological, (b) anthropological, (c) ontical, (d) epistemological, and (e) pedagogical. Integration of

various conceptualizations of caring were performed through a systematic analysis of extant theory about caring in nursing, identifying some common themes, as follows. Ontologically, the "being" of caring is "understood as the human expression of respect for and response to wholeness, an active engagement in the person-to-person process of being and becoming" (Boykin & Schoenhofer, p. 149). Anthropologically, caring in nursing is viewed as an actualizing experience for the nurse as well as the client, and creates meaning in life. Ontically, the caring nurse is viewed as having conscience, competence, and commitment. The caring nurse is viewed as living the personal commitment of service to human kind; directing one's behavior to the "moral fitness of things". Commitment is viewed as the embodiment of function and ethic, and a convergence between the caring nurse's preference and choice. Epistemologically, caring in nursing is known through personal, empirical, ethical, and esthetic means. In personal knowing of caring, awareness of self and others is viewed as essential, and requires authenticity and genuineness. In empirical knowing of caring, the knowledge base of caring is viewed as incomplete, although factual descriptions, principles, theoretical formulations, and explanations are rapidly growing. Competence on the part of the one caring, in order to extract relevant meaning from empirical generalizations, is viewed as essential. Ethical knowing of caring is viewed as respect for person as person and therefore respect for the individual's right to self-determination (autonomy). Implicit in ethical knowing of caring is honesty, genuineness, and trust. Esthetic knowing of caring is commonly viewed "as involving patience and hope on the part of the nurse such that the one being cared for unfolds, and the nurse as artist creates unique approaches to care;

through this engagement with the patient, the nurse truly knows caring in nursing" (Boykin & Schoenhofer, p. 154). Pedagogically, caring in nursing is viewed as beginning with knowing self as caring and cared for, and progresses to knowing others as caring and worthy of care. An understanding of the various values and beliefs of differing cultures is seen as fundamental to knowing others.

This effort at integration of various conceptualizations of nurse caring by Boykin and Schoenhofer is based on the *a priori* assumption that caring is the central concept in nursing. In fact, within nursing, this agreement does not exist. Emergence of numerous theoretical conceptualizations of caring may indicate that a single definition or theory may be unable to capture the differentiated nature of caring. The theories which currently exist require further investigation and validation.

Variables Affecting Caring

Considerable attention has been focused on discerning the elements or antecedents of caring. Gadow (1990), Gaut (1983), and Karl (1990) identify the ability of the carer to have awareness of self and others as separate individuals and to focus attention on others as persons, as necessary elements of caring. "Being there" or "presence" is sometimes used to describe this attending to, or focusing of attention, and is implicitly linked to an attitude of respect for self and others (Kahn & Steeves, 1988; Karl, 1990; Leininger, 1981; Pollack-Latham, 1991; Reeder, 1992; Rieman, 1986a; Roach, 1992). Other nurse theorists have discussed a respect for self and others as essential to "caring" (Deitrich, 1992; Gaut, 1983; Leininger, 1981). The claim that all persons have certain rights that can never be forfeited or retracted underlies the "respect as necessary for caring" notion.

Respect is seen as critical to a discussion of caring and entails an attitude on the part of the carer. A third element of caring described by some theorists is knowledge (Brown, 1986; Gaut, 1983; Kahn & Steeves, 1988; Leininger, 1981; Watson, 1979). Specifically, it is not enough to attend to others and to have respect for human beings; certain knowledge is necessary in order to be able to identify a lack of something required or desired. One further element or antecedent of nurse caring was alluded to by Morse et al. (1990); a set of guidelines or principles to assist the carer in knowing what is "good" for this particular person in this particular state. This idea of caring being context specific is also addressed by Griffin (1983), Leininger (1981), and Ray (1988). Lastly, some nurse theorists suggest that an environment which supports caring and is conducive to "connection" with patients is an essential component of caring (Dietrich, 1992; Ray, 1988; Valentine, 1988).

Clear descriptions of precisely what comprises awareness, respect for self and others, knowledge, caring principles, and a caring environment continue to be investigated.

Perceptions of Caring

In an effort to explicate the "meaning" and behaviors of caring, early nursing investigators concentrated on patient's perceptions of caring (Brown, 1986; Cronin & Harrison, 1988; Drew, 1986; Larson, 1984; Mayer, 1986; Oberst, 1984; Paternoster, 1988; Rieman, 1986a, 1986b; Swanson-Kauffman, 1986). This research was followed by an even greater volume of inquiry into nurse's perceptions of caring (Ford, 1990; Forrest, 1989; Kahn & Steeves, 1988; Komorita, Doehring, & Hirchert, 1991; Mangold, 1991; Morrison, 1991). This earlier focus on nurses's perceptions of caring has been a ready

source of criticism (Morse et al., 1990; Paternoster, 1988; Valentine, 1991a). Perhaps as a result, nurse theorists during the late 1980s through to 1993 focused nursing research on comparing and contrasting patient and nurse perceptions of caring in order to further explicate the meaning of caring (Boyle, Moddeman, & Mann, 1989; Keanne, Chastain, & Rudisill, 1987; Larson, 1987; Smit & Spoelstra, 1991; von Essen & Sjoden, 1991a, 1991b). Caring has been studied both qualitatively (Brown, 1986; Drew, 1986; Ford, 1990; Forrest, 1989; Kahn & Steeves, 1988; Miller, Haber, & Byrne, 1992; Paternoster, 1988; Pauly, 1993; Reiman, 1986a, 1986b; Swanson-Kauffman, 1986) and quantitatively (Boyle, Moddeman, & Mann, 1989; Cronin & Harrison, 1988; Keane, Chastain, & Rudisill, 1987; Komorita, Doehring, & Hirchert, 1991; Larson, 1984,1986,1987; Mangold, 1991; Rosenthal, 1992; Smit & Spoelstra, 1991; von Essen and Sjoden, 1991a, 1991b). In the qualitative studies, primarily phenomenological methods were used in which the research questions were very general, usually open-ended, and answered through participant observation and unstructured interviews. Operationalization of caring through instrumentation in the quantitative studies, involved the use of the two tools based on Watson's (1979) ten carative factors: the Caring Behavior Assessment (CBA) developed by Cronin and Harrison (1988) and the Caring Behavior Inventory (CBI) developed by Robinson Wolf (1986). The Caring Assessment Instrument (CARE-Q) developed by Larson in 1981 was the third instrument used with a substantial body of evidence supporting its efficacy (Keane, Chastain, & Rudisill, 1987; Komorita, Doehring, & Hirchert, 1991; Larson, 1986,1987; Mangold, 1991; Mayer, 1986; Rosenthal, 1992; Smit & Spoelstra, 1991; von Essen & Sjoden, 1991a, 1991b). Reliability and validity

were established and reported in all studies. Generally, these studies restricted subjects' opportunities to define care by presenting them with behaviors already believed to be caring or non-caring, and asking them to rank-order them or sort them according to priority. Some investigators relate that participants complained about the restrictive nature of the study, suggesting that a qualitative design might provide richer data in terms of perceptions. All investigators reported the instrumental and affective domains of caring from both the patient and nurse perspective, however, individual factors or constructs were not noted as identical. Moreover, with the exception of Keane, Chastain, and Rudisill (1987), investigators reported that clients tended to focus more on the instrumental tasks of caring, while nurses focused more on the affective domain of caring. This exception to the findings may relate to the rehabilitative setting of the study, in which a different philosophy generally guides nursing practice and patient expectations. However, investigators' findings suggest it is questionable whether the experience of caring is the same for the giver as the receiver.

Caution must be exercised in generalizing the results from these studies. All three instruments were designed with an acute care environment as the target. In addition, though the context of the various investigations was an acute care setting, variety existed as to exact context: neonatal intensive care units, a labor and delivery unit, coronary care units, oncology units, a medical unit, and a surgical unit. Furthermore, participants were required to respond without any specific situation as the focus or context of their perceptions. Benner (1984) argues that the context of caring is essential to describing caring and expert nursing practice.

Outcomes of Caring

Investigations into the physiological and non-physiological indices of nurse caring appear to be the most recent area of interest. A total of seven studies were located which focused on the outcomes of nurse caring (Duffy, 1992; Ford, 1990; Miller, Haber, & Byrne, 1992; Paternoster, 1988; Pauly, 1993; Rieman, 1986a, 1986b; Valentine, 1991b). Within these studies, five investigators examined the non-physiological indices associated with caring. Three focused on patient outcomes (Paternoster, 1988; Pauly, 1993; Reiman, 1986a, 1986b), while two investigators focused on nurse outcomes of caring (Ford, 1990; Miller, Haber, & Byrne, 1992). Generally all investigators reported a positive relationship between perceived nurse caring and positive patient outcomes. Paternoster (1988) described client's responses as falling into four broad categories: feeling good, feeling secure, feeling connected with the nurse, and feeling validated. She indicated that patients had difficulty relating any degree of depth in their responses. Pauly (1993) reported that clients described their response to nurse caring as assisting them to heal, while Reiman (1986a) reported that clients expressed feeling comfortable, secure, relaxed, and at peace as a result of experiencing nurse caring. In the two studies which reported nurses' responses to caring, Ford (1990) indicated that nurses were enriched by their experiences, while Miller, Haber, and Byrne (1992) related that nurses felt a deep sense of satisfaction in caring interactions.

Two studies attempted to measure physiological indices of nurse caring through quantitative approaches (Duffy, 1992; Valentine 1991b). Duffy (1992) found a positive correlation between nurse caring behaviors and patient satisfaction, however, was unable

to substantiate a relationship between nurse caring and health status (as measured with the Sickness Impact Profile). She cited lack of sensitive and accurate measures, and diversity of the sample as possible explanations for her findings. Valentine (1991b) found the degree to which nurse caring occurred between patients and nurses as perceived by patients contributed significantly to the outcome of post-operative complications. No studies were located in which physiological indices of nurse caring were reported for nurses.

Only immediate, short-term non-physiological and physiological effects of caring have been reported so we have no understanding of the possible long term consequences of nurse caring, in terms of patient outcomes or nurse outcomes. Furthermore, contextual elements of caring which may influence caring outcomes have not been investigated.

Settings

All but five studies used an acute care setting. Of these five studies, one involved home care client's perceptions of nurse's caring (Smit & Spoelstra, 1991) and the other four (Kahn & Steeves, 1988; Komorita, Doehring, & Hirchert, 1991; Mangold, 1991; Morrison, 1991) included diploma students, baccalaureate nurses, masters of nursing students, educators, and nursing managers as samples. No studies were located which utilized a health promotive setting. Several regions of the United States and Canada were included in the studies, as well as research from Wales and Sweden. Collectively, the studies included both males and females, but not all studies included both or in equal numbers. There were no children studied.

Summary

A review of the literature on caring reveals that, in fact, a substantial amount is known about the topic. The most salient points are as follows. First, there is generally, consensus that caring is an important phenomenon for nursing investigation. Critical reflection on the question, "what is caring?", is evident in the literature. Efforts to integrate various perspectives on caring are demonstrated, although its exact nature is not yet understood.

Second, nurse researchers are suggesting that caring is context dependent, whereby "clinical" setting is but one aspect of the context dimension. Other aspects might include both clients' and nurses' expectations and prior experiences, factors influencing the coming together of nurses and clients, and the nature of the environment in which the coming together occurs.

We do not know if health status determines patients' perceptions of nurse caring. For example, does the sicker patient focus more on physiological aspects of caring, which in turn guides the nurse in caring behaviors? Nor do we know the nature of patient outcomes related to caring if the patient is not in need of physical healing.

In light of the above, this study was designed to examine clients' perceptions of nurse caring in a health promotive context. An inductive approach was chosen in an attempt to understand clients' perceptions of caring, and capture its context specific nature.

Research Question

The research question for this study was, "What are clients' perceptions of nurse caring in a health promotive context?".

CHAPTER III

Methods

The purpose of this study was to examine nurse caring from the perspective of clients in a health promotive context. The method used in this study was ethnography as defined by Spradley (1979), that is, the use of ethnoscience and ethnography combined. Ethnoscience, a linguistic technique premised on semantic principles, was used to elicit the cognitive dimensions, that is, the "what" of the role(s) of the professional nurse in a health promotive context. The procedures and principles of ethnoscience were designed to enable the investigator to elicit and order implicit knowledge that informants had about one dimension (role of the professional nurse) within their culture (a health promotive context). Ethnography was also appropriate, since a health promotive context or setting is conceptualized as a discrete culture whose members shared common experiences, expectations, and knowledge. When I asked one informant if the health promotive setting was part of the real [health care] world, the response confirmed the idea that it was a separate subculture, "--- it's in the real world but it's on its own in the real world. Its own little subculture"[Subject B, Interview 3, Page 13, Lines 347-348]. Spradley (1979) indicates, "rather than studying people, ethnography means learning from people" (p. 3). Since the researcher views knowledge as something which is obtained through an understanding of meanings of behavior perceived by those experiencing that behavior, efforts were employed which sought to explain how the study population perceived this setting in its own terms. Focusing on the informant's point of view, the emic approach is based on the underlying assumption that the informant is the one who best knows his/her

own inner state. As suggested by Robertson and Boyle (1984), to gain knowledge of cultural meanings, the researcher explores the language of the informants, gathers data on their perceptions of reality, and identifies their conceptual frameworks.

Research Techniques

Ethnographic interviews, involving the sequential completion of a series of interviews, was the data collection technique in this study. The Developmental Research Sequence developed by Spradley (1979), consisting of twelve major tasks designed to guide the researcher through the process, was closely followed as the framework of investigation. Interviews were conducted with five informants from a variety of health promotive programs offered at a health promotion resource center affiliated with a large urban hospital. Informants were interviewed at a time convenient for each, in a quiet room located within the health promotive facility, although another site of their choice was offered. Participants ranged in age from 43 - 51 years, had accessed resources at this site on at least two previous occasions, with four of the five informants being employed outside the home. A biographical overview of the informants is presented in Table 1.

Table 1
Biographical Characteristics of the Informants

Informant	Characteristics				
	Age	Sex	Occupation	Previous Number of Contacts	Reason for Most Recent Contact
1	43	F	Education Field	8	Follow-up
2	51	F	Service Industry	3	Information seeking
3	53	F	Home maker	3	Check-up
4	43	F	Service Industry	2	Follow-up
5	50	F	Education Field	2	Follow-up

The first round of interviews was completely unstructured; I only asked the informants to tell me about a recent positive experience they had had at the health promotive setting. Interviews were audiotaped, transcribed, and analyzed before proceeding to the next round of interviews. Impressions about the atmosphere of the interview were noted and recorded in a journal. The analysis of round one interviews led to the development of hypothesized domains or dimensions of the positive experience. At this early stage, two major domains appeared to encompass all other sub-domains and corresponding cover terms and included terms: "the role of the professional nurse in being with the patient (working independently) in a health promotive context" and "the role of the professional nurse in working with other health care professionals in a health promotive context". Round two interviews were more structured with the use of verification, descriptive, and contrast questions to verify these two major domains, and the sub-domains, cover terms, and included terms within them. Many contrast questions during round two interviews resulted in the discovery of dimensions of contrast between the roles or contrast sets of the professional nurse within each of the two domains, which led to details about how one role or term was different than the other. Taxonomies were constructed to identify the relationship of sub-domains within the major domains. Card sorting was used during interview three whereby informants were asked to sort cards to verify taxonomies, to determine semantic relationships of terms within the taxonomies, and to validate dimensions of contrast for componential analysis. Informants were presented with the taxonomies in pieces and the interview involved working "up" through

the interview from sub-domains, to major domains, confirming relationships of terms, and dimensions of contrast between the roles or contrast sets.

Data Analysis

Data analysis occurred in the following manner. First, the interviews were transcribed and each transcript was reviewed word-for-word to check accuracy. Color coded copies of each transcript were made to facilitate the ongoing identification of informants and quotation sources as analysis progressed. The transcripts were then analyzed for preliminary domains using a Semantic Relationship/Domain Worksheet (see Appendix A) designed for this purpose, as described by Spradley (1979). This process led to the development of hypothesized domains, cover terms, and included terms. When a transcript appeared exhausted for possible domains, cover terms, and included terms, a Summary of Tentative Domains was compiled. Using the Semantic Relationship/Domain Worksheet, color coded 3 by 5 cards were developed for each cover term and corresponding tentative included terms. Cards were then mounted on a matching colored sheet. Throughout the analysis process, notations were made on transcripts and in a journal identifying possible connections, ideas, and tentative hypotheses. Subjective impressions were also recorded in a research journal. All notations were re-read periodically to facilitate insights and to prevent the loss of familiarity with data and corresponding ideas. The one-page card cover term sheets were then used with subjects to verify tentative domains, sub-domains, missing cover terms, and additional included terms, where the portion of the sheet not covered with the notation/tentative domain was used to record additional uncovered data. Taxonomies were then diagrammed on poster

sized paper depicting tentative relationships among domains, sub-domains, cover terms, and included terms. It was at this point in the analysis that the two primary domains of "the role of the professional nurse in being with the patient (working independently) in a health promotive context" and "the role of the professional nurse in working with other health care professionals in a health promotive context" emerged. Round three interviews were then used to: verify the taxonomies comprising sub-domains and their relationships (example, ways a professional nurse gives information and kinds of information a professional nurse gives); to verify contrast sets (example, health promoting role and health resource role); to collapse categories or contrast sets (example, teacher, leader, and collaborator collapsed into collaborator) as appropriate; and to identify and verify additional areas of contrast (example, how listening in the health resource role is different) within the two major domains. The emphasis in round three interviewing was to elicit new areas of similarities and differences between the contrast sets or roles, and ensure data saturation of the two major domains, and identified dimensions of contrast. Two paradigm spreadsheets were created, one for each major domain: (1) " the role of the professional nurse in being with the patient (working independently) in a health promotive context" and (2) "the role of the professional nurse in working with other health care professionals in a health promotive context". An Inventory of Verified Domains spreadsheet was then created in which all domains verified by three or more informants, were listed. Insufficient data existed to verify the sub-domains (example, kinds of professional nurse caring), dimensions of contrast (example, listening), and contrast sets (example, caring role), within the major domain (2)"the role of the

professional nurse in working with other health care professionals in a health promotive context". In light of this, further data analysis involved focusing on the contrast sets (roles), their dimensions of contrast (examples, information-sharing) within the domain of (1) "the role of the professional nurse in being with the patient (working independently) in a health promotive context. The contrast sets were then analyzed in terms of the identified dimensions of contrast. These dimensions of contrast were then collapsed into major themes.

The final dimension of analysis, in which cultural themes are stated as brief assertions about the setting, occurred as the results were written. The investigator consulted with members of the thesis committee for direction and input, throughout.

Reliability and Validity

Issues of rigor are of serious concern to the qualitative researcher. Accurately rendering the lived experience of study participants such that the human phenomenon under study is presented as it is perceived by those participants is the primary responsibility of the investigator (Sandelowski, 1986). In qualitative research, the procedures for enhancing rigor are to a degree determined by chosen methodology and differ significantly from approaches used in quantitative research (Sandelowski, 1986). The sampling approach (Morse, 1986), and the general approach (Sandelowski, 1986), are two approaches to evaluating reliability and validity of qualitative research. While the former focuses predominantly on sampling, the latter stresses a number of issues. Given the study design, both of these approaches will be discussed in this section, as they relate to this study.

Sampling

Non-probability sampling with a purposive technique met the needs of this investigation. Volunteer informants who had experienced a face-to-face nurse-client relationship in a health promotive setting were recruited. Firstly, inclusion criteria for subjects were established, identifying appropriate informants as those who: (1) were receiving health promotive care from a registered nurse, (2) had received health promotive care from a registered nurse in the previous three months, (3) were able to speak and understand English, and (4) were cognitively able to reflect on and verbalize experiences and perceptions related to the topic. Criteria for exclusion from the study were informants who: (1) were younger than eighteen years of age, (2) were unable to commit to a minimum of four and a half hours of time for interviewing, and (3) were analytic informants prone to translation competence (as described below). Justification for the inclusion and exclusion criteria follows.

Spradley (1979) identifies the need for an informant to have current involvement in the cultural scene under investigation as a major change in perspective occurs when an informant leaves a cultural scene. Since cultural knowledge is less accessible and more difficult to recall if it is not being used, only informants with recent or current cultural knowledge were accessed. Although a wide variety of health care disciplines offered services in the setting under study, since the perspective under question was in relation to nurse caring, only informants who had engaged in nurse-client relations were viewed suitable for access. Informants who were able to provide a semantic vision of their world were crucial to the quality of the work. Since the framework for investigation (The

Developmental Research Sequence Method) in this study requires a range of four to six hours of interviewing, individuals who were unable to commit adequate time were not included in the study (Spradley, 1979). Furthermore, Spradley warns of the tendency of some individuals to describe events and actions with significant analysis of meaning, which he refers to as translation competence. Finding it almost impossible to talk to outsiders (researchers) without first analyzing their culture from an outsider's perspective, these subjects are a major concern in terms of recruitment of subjects since initiation, development, and maintenance of a productive informant relationship is hindered. With this in mind, all informants were told they would be interviewed one or more times without a firm commitment as to the exact number of interviews. However, no subjects were assessed as "translating" during the first interview. In fact, on more than one occasion during the interviews, subjects indicated that they did not know the language or words used by myself or others (in health care settings), so chose their own words. As one subject said, " I don't speak medicalese"(Subject A, Interview 1, Page 1, Line 44).

The first approach to recruitment of participants was the placement of an advertisement for volunteer subjects, in the resource center (see Appendix B), whereby interested people could contact the investigator by telephone. This initial effort was not successful after one month, so letters of initial contact were mailed to potential informants following screening by the Clinical Nurse Specialist (see Appendix C). This screening involved the Clinical Nurse Specialist telephoning potential informants to determine if they wished to be informed of the research through a mail-out. The initial contact letter was then either mailed to interested potential participants, or given to them

in person during their next visit. Interested participants then telephoned the investigator, and were given additional information regarding inclusion criteria and necessary time commitment. Although potential informants were given the option to set up an initial interview time at this point, or to contemplate involvement and notify the researcher by a mutually agreed date, all but one scheduled the first interview during this initial contact. After nine months of recruitment, 3 of the desired 4 to 8 participants had been obtained. During my investigation of this recruitment difficulty, the Clinical Nurse Specialist conveyed to me, that the substantial time commitment of six hours interview time was a major barrier to potential subjects participating. Members of the thesis committee were contacted at this point to determine the best course of action. Preliminary analysis of the data from the 10 interviews completed at that time, indicated some saturation with recurrent themes. The decision was made to attempt to recruit two more subjects for purposes of validation involving one or two interviews. After one month, two additional subjects were recruited. The result was a homogeneous group of informants as shown in Table 1 (see p. 23). This group was all self-described as having had a positive experience with a nurse within the health promotion program. This met the first evaluative criteria of appropriateness.

Since adequacy is evaluated by the completeness, and amount of information contributed by informants (Morse, 1986), the two validation participants were interviewed to gather new information (ensuring saturation of research categories), assess repetitiveness of information, and ensure a sense of coherence (Morse, 1986). The quality of the data was determined as adequate following the two validation interviews, when

confirmation of previous participants' data was received, and no new domains or dimensions of contrast were uncovered. The second criterion, adequacy, was reflected in the quality and sufficiency of data. Negative cases were not sought in this investigation, however, data analysis was verified with original informants at each progressive step of interviewing, as well as during the two specific validation interviews.

General Issues of Reliability and Validity

Sandelowski (1986) identifies auditability, or the ability of another investigator to follow the decision trail, as an appropriate criterion of reliability. The decision trail of this investigation is presented throughout this thesis and stands to be evaluated by the reading audience. Wherever quotations are used throughout Chapter IV, the subject letter, interview number, page number, and line numbers will be indicated to ensure both rigor and auditability. In addition, the quotations will be somewhat edited in terms of removal of repeated words, and voice pauses for ease of reading. For example: "Definitely. Definitely. Here I was not not--I was--I was um, respected as a person.", would be edited, and referenced as:

> Definitely. I was respected as a person. [E.2.5.113-114].

Though some investigators (for example, LeCompte & Goetz, 1982) indicate that the data collection and analysis techniques used in qualitative research are the source of high internal validity, Sandelowski (1986) suggests credibility as a more appropriate criterion. Credibility of a study is apparent when the descriptions and interpretations are such accurate renditions of the phenomenon that those who have had the experience can recognize it from these descriptions, as their own (Sandelowski, 1986). This criterion was

met during the final round of verification interviews with participants, and during the interviews with the validation subjects. Final determination of the credibility of the findings in this study awaits scrutiny by its readers.

Finally, Sandelowski (1986) suggests rather than generalizability, a qualitative study must strive for "fittingness". In "fittingness", the findings must "fit" the data from which they were derived, and the study findings must "fit" into other situations or contexts. Beyond verification of the procedures previously discussed, identification of whether this study meets this criterion awaits distribution of findings and subsequent reactions.

Ethical Issues

Ethical clearance was sought from the hospital which administered the health promotion program, and from the health promotion setting from which the informants were sought. Written consent (see Appendices D and E) was obtained from all participants, prior to the initial interviews and immediately following the researcher reading the informant information sheet (see Appendix F) regarding participation in the study and the answering of questions. The informants were provided with a copy of the information letter and signed informed consent for future reference. Informants were clearly informed that they could withdraw at any time. Organizational setting and individual anonymity was maintained within the study report. Secured audiotapes will be kept for seven years, while secured transcribed interviews will be kept for an indefinite period of time.

CHAPTER IV

Findings

As identified in the Data Analysis section (refer to page 22), original findings were analyzed and sorted into two major domains, however, insufficient data existed to verify the domain of the professional nurse working with other health care professionals. In view of this, findings presented will relate to just one domain: "the roles of the professional nurse in working with clients (working independently) in the health promotive setting", and themes of the health promotion setting. While the first group of findings encompasses the *detail* of the health promotion subculture, that is the *roles* of the nurse, the second group of findings encompasses the *broad* themes representative of the health promotion setting. Clarification of the concept of professional occurred throughout the study. As such, it will be presented first, followed by the four major roles of the nurse in a health promotive setting. The three major themes arising from the detail of the four major roles, will comprise the final portion of the findings.

The Concept of Professional

In this study, subjects were interviewed in order to understand their perceptions of a positive encounter with a nurse in a health promotion setting. Initially, and throughout subsequent interviews, subjects spoke repeatedly of 'professionalism' and the professional role of the nurses in this setting. In first round interviews all subjects shared details of previous encounters with non-professional or unprofessionals referred to as 'business-like professionals'[A1.1.36], or 'more-professional professionals'[B.2.2.305] in health care settings other than health promotion. Informants compared and contrasted

these previous encounters with the *real* professionals encountered in this setting. In the former descriptions, informants depicted all types of health care professionals negatively, not just nurses. For most subjects, the positive encounter they described to me, was their first positive encounter or interaction with what they considered, a *real* professional nurse.

This real professional role was the foundation of subsequent professional nurse roles defined by subjects. The real professional nurse role was recognizable to subjects through various physical, emotional, and philosophical values or attributes. That is to say, real professionalism permeated not only the nurses' task behaviors, but was also recognizable through the emotional and philosophical values of the professional nurse:

> She wasn't task-oriented like she had an agenda. I mean she surely did and that's part of being a professional but she was willing to be taken off the sides a bit because of someone's needs[A.2.5.93-94].

> There was the caring and the concern but it was a different type of professionalism. All down the line, he did wash his hands before and after. The whole bit, wore the rubber gloves. But maybe it was more, a feeling that I had. [B.2.13.322-325].

> We throw the word professional around any more so it refers to so many things. But this is what a professional nurse would be, 'someone who can separate herself and her personal concerns from her professional work, and actually be with the person that she's with'[A.2.4.87-88].

Informants believed the philosophical attributes of the professional nurse arose from the nurse's belief about others as subjects (versus objects), and a willingness to do more than what was expected of them:

> [Professional is the] perception of who you are dealing with. Work would be you're dealing with a 'what', and profession you're dealing with a 'who'[C.2.20.509-510].

> Professional is probably not the word I would choose. Not because they're not professional, but because the professionalism denotates [sic] distance. In me thinking about this, I felt more like [nurse] was a partner, rather than someone distant. She was a partner, which I would say is much higher than professionalism. [Nurse] had kindness and compassion and she treated me like a human being. She became a partner...so it went beyond professionalism [G.1.15.367-383].

This dimension of "going beyond" within real professionalism, was discussed by several subjects as "gone a step past" [B.3.15.401], " going beyond their job description" [A.2.6.131-133] and "going that extra mile" [B.2b.8.195]. In many instances, subjects linked this "going beyond" to time, in that, 'time was taken' (from other activities), or 'given to' the client, or the client was not rushed. Informants indicated that the nurse must have worked beyond her normal scheduled number of hours in order to take time with every client. Subjects indicated that they could "feel" this 'going beyond' attribute of professionalism, but aside from the time aspect, informants experienced some difficulty in describing how they could tell when it was there:

> Just kind of a gut feeling I had about them. They had a positive attitude about what they were doing. And there again, they enjoyed what they were doing [B.2b.9.208].

Informants indicated that the only way to determine if a nurse was professional or not, was through first-hand experience. For most subjects, they had encountered a professional nurse for the first time in this particular setting, and felt changed as a result of it. When the researcher asked one informant if anything had changed as a result of her positive experience she replied: "Mostly I realize the importance of personal power. I have the power to manage myself - no one else"[A.1.29.1344].

The findings that follow represent the four roles of a professional nurse in a health promotive setting.

Roles of a Professional Nurse in a Health Promotive Setting

The informants described four distinct roles of the professional nurse in a health promotive setting: (1) caring role, (2) health promoting/health advocating role, (3) collaborating/client advocating role, and (4) health resource/communicating role. Within these four roles, subjects identified values or attributes primarily relevant to the professional nurses' role in working with clients (working independently). In some instances, subjects identified how values or attributes associated with each role, change as the nurse moves from the domain of working with clients to working with other health care professionals. These findings will be presented within the attributes of the roles in which they were identified. From the initial categories of roles, final validation interviews, and analysis of data, a taxonomy of "the kinds of roles of a professional nurse in being with the patient (working independently) in a health promotive setting", was developed and is presented in Figure 1.

Figure 1. **Taxonomy of the kinds of roles of a professional nurse in a health promotive setting.**

Professional Nurse Role		
Caring Role	Present-oriented	Positive regard
	Authenticity	Attentive
	Genuineness	Acceptance
	Information-sharing	Appearance of not being rushed
	Really listening	Self-awareness
	Touch	Self-caring
	Team work	
Health Promoting/ Health Advocating Role	Future oriented	Health as a Goal
	Health focus versus illness focus	Positive actions
	Positivity versus negativity	Holistic approach
	Proactivity versus reactivity	Focus on improvement versus maintenance
	Build on what is right	
Collaborating/ Client Advocating Role	Cooperative relationships	Answering questions
	Respect for self and others	Knowing where things are at
	Client-centered	Feeling listening
	Situation-specific	Reassurance
	Absence of demands	Maintaining order
	Remember clients by name	Decisiveness
	Recognize clients expertise	Patient advocacy
	Not attempting to take power or control	Leadership
	Taking time	Knows when to refer
	Honesty/Truthtelling	Expertise
	Information-sharing	
Health Resource/ Communicating Role	Information-sharing	Honesty
	Skilled	Willingness to share information
	Knowledgeable	Availability
	Expert	Knows what client needs
	Listening	Trust
	Being open	Puts the client first
	Turn-taking or pacing	Non- threatening

Caring Role

The predominant focus of the caring role in the health promotive setting is ministering to the psyche of the client. When identifying domains in which this role exists, informants only spoke of components of this role within the domain of the professional nurse working with clients, and did not speak of the caring role within the domain of the

health professional working with other health professionals. In the caring role, the nurses' motivation is embedded in a capacity to care and be authentic:

> All you can teach is that people be as genuine inside themselves, and then in their expression of themselves, as possible. What's it called? It's --the word's authenticity[A.3.53.1308-1311].

When subjects identified the various aspects of the caring role, they frequently referred to the nurse as "really caring"[C.2.17.452], "so very, very caring"[A.2.41.956], capable of "professional caring"[B.3.15.407], and having a "caring-nurturing way"[B.1.9.190]. Subjects identified major characteristics or components of the caring role as information sharing, "really" listening, touch, and team work.

Within the caring role, information-sharing involves the nurse sharing details about what is to be expected, what is happening or is about to happen, who the health care team members are, the time involved, and a broad overview of the whole process. The main purpose of this detailed information-sharing is to prepare clients for their participation in the impending activity, and to frame the activity as 'doing with' rather than 'doing to' in nature. The information is present focused, rather than future-oriented, and is of immediate utility to the client. Informants reported that this information-sharing created trust in the nurse.

Another significant aspect of information sharing in the caring role involves the absence of, what one informant described as, " a set pattern of information delivery". The 'whether you need this or not, this is what I have to tell you first'[A.2.54.1267-1269], approach to information-sharing. The individualization of a basic process, comprising

sharing the broad picture, several details, and finally, closure, is in sharp contrast to the "...series of commands..."[A.2.23.544], approach of information sharing described by one informant, when contrasting this information-sharing with previous experiences.

> When I was here, I had the full attention of [Nurse]. We were in this room, and she said, 'Take your time'. I was not hurried at all. I finished all my questions[E.2.8.183-185].

Several informants described listening within the caring role. Listening within this role involves listening to what is not said by clients as much as to what is said, with the primary purpose being to determine the emotions and feelings of the client in relation to the subject matter. This is perhaps best captured by these words:

> She was paying attention to not only what was said, but what was not said. While she was listening to me... she was attentive to how I was feeling[A.2.3.52-63].

The purpose of this listening appears to be related to identifying the client's emotions, and subsequent opportunities for the nurse to attend to these emotions. Most informants discussed this aspect of the caring role in great detail, and were particularly attuned to the nurse's body language and eye contact while she was listening.

Touch was described as another significant aspect of the caring role. While some subjects described touch as a means to form a connection with the nurse, others identified the negative aspects of touch, if prior connection did not exist:

> You know, just a slight touch on the arm. I think that helped. So that you don't feel so detached like a number [E.2.6.129-135].

Conversely,

> I don't want people I don't know to touch me -- that's just not right. I have to know who that person is and, in a sense offer permission, silently [A.1.28.1288].

Within the health promoting setting, where contact between client and nurse is of a relatively brief nature, touch can be a means to form the necessary connection, and demonstrate the nurse's caring for the client. However, touch can also be viewed as unnecessarily intrusive in a setting where there is often absence of any sort of physical need, which necessitates nursing activity in the form of physical touch. It appears that "knowing" the nurse is a necessary antecedent to touch between nurse and client.

All informants described team work as a significant factor within the caring role. Informants viewed themselves as members of that team and believed they knew when teamwork was or was not present.

> [There was] a genuine positive regard. We are both in this world together so let's do what we can. As though they knew something that I needed to know and tomorrow I may know something that they need. You know, so it's like a peer relationship instead of any kind of hierarchical thing. We were simply teaming up together to do the job. [As for the other health care professionals], it felt like they had unified themselves over this case when I was not even present. And I'm sure they did. And they apparently had a team meeting and voiced opinions. That's what it seemed to me[A.2.8.172-184].

Through genuine positive regard from the nurse, clients view themselves as members of the team, with caring resulting in a "doing with", rather than 'having done to'. In this way, teamwork is a part of caring and leads to increased trust on the part of the client. Within the caring role, the nurse teams up with other health care professionals, as a result of a positive regard for others and a belief that unifying or "teaming up' will get the best client results.

All informants described attention and acceptance as significant factors in the nurse caring role. The amount of attention shown the client by the nurse leads to feelings of validation and acceptance on the part of the client. The nurse's degree of attention to the

clients' physical and emotional concerns, was without exception, not expected or anticipated by clients:

> And I asked her, "Do other people do this too?", because I do feel foolish in a way of coming and wasting time. And she says, "No, just last week there was another lady in for the same reason, so you're not alone. Not at all."[E.2.4.87-90].

> The level of caring far surpassed what I expected, or even what I needed, because I wasn't worried about that. I didn't need reassurance, the gentle treatment that I was given, would have given me more reassurance about not to worry about it [B.1.11.228-231].

> So that's all they can do is "journey with you". If you're on a path that you've never been on before, you don't want anyone blowing out the candles and leaving you alone. And so maybe they walked in front and held the candle [D.1.26.625-633].

This degree of attention or acceptance, which exceeded what the clients expected, led to feelings of validation on the part of the client. As a result, clients felt that their help-seeking behavior was appropriate, even though their health concerns were not 'life-threatening'. Further, this validation, as an aspect of the caring role, created a sense of connection or 'being with' the nurse.

All informants described the "not rushing" aspects of the caring role. Within other roles, informants spoke to the significance of time in terms of "taking time", "giving time", and "making time". The primary difference within the caring role was that nurses *gave the appearance* of not being rushed, regardless of the reality. Since rushing gives "negative messages" to clients, as a manifestation of the caring role, the nurse attempts to give the appearance of not being rushed, ensuring these negative messages do not get transmitted to clients:

> Rushing lets people think that you're so self-important and you really can't get a grip on yourself. As a patient I wouldn't want that to happen. If I saw somebody buzzing in and out of the rooms, I think "My God! -- are they going to treat me

> that quickly?" Because the more rushing there is, the more likelihood that there is for error. To speak to a person in a non-rushing fashion lets them know that you really care about them [A.3.32.780-789].

An attribute of the caring role is the nurse's deliberateness in not rushing. This 'not rushing' appears to be linked to the notion of being full of care, not careless, thus minimizing the possibility of making an error.

The final aspect of the caring role involves self-awareness and self-caring as necessary components on the part of the nurse. As one informant described:

> I can say that the really good nurses would probably have awareness of how they are feeling towards their patients and would evaluate periodically, 'How am I treating my patients here?', 'Am I really treating them the way I would like to be treated myself?', or 'Am I slipping?'. Things that I would not want to have done to me. Am I sort of slipping into that because I'm tired, overwhelmed, and I need a break. I need to look after myself. So I think a really good nurse would sort of evaluate periodically to make sure that this wasn't happening. And would be wise enough to take steps, to look after themselves so that this wouldn't happen [C.2.17.434-446].

The same informant expanded her description further by indicating: "...look after yourself first and then you can give to others"[C.2.19.482]. It would seem that the caring role is self directed as well as other directed, and the performance of the former determines the quality of the latter. Informants believed that within the caring role, the nurses in this setting were caring for themselves and had reached a desirable degree of balance between personal and professional life. Throughout the data collection, informants repeated how calm these nurses were and related this to their ability to be caring toward the clients.

Health Promoting/Health Advocating Role

The health promoting role primarily involves the instruction of others in their responsibilities in the health process. The role was described by informants largely in

terms of the nurses' perspective or outlook, with some identification of its affective characteristics. This role is enacted by the nurse when working with clients, as well as when working with other health care professionals. In the health promoting role, the nurse emphasizes health, positivity, and proactivity, rather than disease, negativity, and reactivity. Of the four roles described by informants in this study, this role seemed to be the most challenging to describe. Frequently, the role was identified by informants through descriptions of what it was not, rather than what it was. This may, in part, be related to the future orientation of this role, as opposed to the situation specific, or immediate nature of the caring role.

The following excerpt, which largely describes the traditional illness focused role of the health care professional, possibly provides the best clarity regarding the differences between the health promoting role of the nurse, and the traditional illness focused role of health care professionals:

> I think they [traditional illness focused health care professionals] have chosen to be in helping professions because they like people to need them and so, when someone is not well, that's their best time. They can feel productive and they compare, 'My day was harder than yours 'stories. 'I had an emergency here - we had a rough one there', 'their day was really busy': of course they're professional enough not to use names or to give specifics. It seems they get off on the downside of living. When there's a flaw, they get off on that. That kind of makes sense - In a way that's what they're there to fix. But I wonder what would happen if they changed their attitudes to: 'Let's champion the cause of health here', even while they're fixing what is not right. What if they looked for the answer to 'What is not wrong?'. I get the feeling that the people I worked with here, and (Nurse) in particular, wanted to have as many human beings as possible walk out of here in good health, as good as it could be, and go on having lives that were maybe even improved [as a result of] what had happened here [A.1.23-24.1092-1125].

The informants identified an attribute of the health promoting role as building on "what was right", or that which led informants to believe that they were doing something right in terms of health promoting activities.

Informants believed nurses in non-health promoting settings primarily achieve satisfaction and a sense of competency from their efforts or techniques of intervening in disease and illness. They also believed that the nurse in the health promoting role gains satisfaction from seeing others healthy and from the idea that progress is being made overall toward greater health. As one informant indicated: "The techniques of doing something are the substance under which you operate but it's not the goal!"[A.2.7.148-151]. Informants indicated that health promoting nurses describe the techniques and activities to be performed in a matter-of-fact way, with emphasis not on the activities, but on the future consequences or results. Informants described how this led to trust in the nurse, as her motives were apparent: she is looking at the big picture and the desired outcome. Health is the goal.

> She saw the picture for the end result, [which] she saw as being positive. And when you see the end result as being positive then all the steps leading toward it are positive ones heading to that goal [A.2.19.430-433]

The "positive steps" leading to a positive goal consist of: being matter-of-fact, sharing answers to questions in a positive way, giving hope that answers (that is, results) will be of a positive nature, and framing the experience as a success. The client sees the nurses' health promoting role as assisting the client through a process. As one informant described: "[It] is not so much get out there and be alone or do your thing, but help yourself so that you're taking a reasonable share for your health and that is psychological

or otherwise" [A.3.11.264-267]. Furthermore, informants believe there is a recognition on the part of the nurse that a continuum of health care environments exists for the client:

> She recognized this process of what you've been going through didn't end when you walked out the door[A.2.59.1373-1375].

This notion of connecting components was noted in several aspects of the health promoting role: health promotion activities or steps (forming a process), multiple settings (crossing multiple health care settings), and the client viewed as a whole (holistic).

Informants believed the nurses' holistic approach to health was the key to having them involved in their health care. They believed they have the ability to pursue improved health (versus independently combat disease or resolve an illness). Informants believed that the nurse in the health promoting role focused on their overall health, rather then focusing on disease or illness, which would have been the result of fragmentation of their health:

> The whole goal was excellence in health, rather than excellence in only one little part [A.1.25.1145-1147].

Further,

> So, everything is very open here. I think that they really advocate for you to be part of your own health care [D.1.12.277-278].

Informants identified that the nurses' instruction as to their responsibilities in the health process did, in fact, lead to a sense of personal responsibility within themselves. Since the focus of the health promoting role was toward the future, informants felt that an opportunity existed for them to become involved, or what they described as "proactive". Furthermore, this proactivity was linked with the idea that maintenance of health is less desirable than the actual improvement of health.

Collaborating/Client Advocating Role

The collaborating role of the professional nurse in the health promoting setting primarily involves the establishment of relationships of a cooperative nature. These cooperative relationships are grounded in the nurse's respect for self and others, are client-centered or situation-specific, and lead to improved quality in client health outcomes. Enacting the collaborating role, the nurse functions within the domain of working independently, as well as in the domain of working with other health care professionals.

Three specific kinds of respect exist within the nurses' philosophy: the nurses' respect for the client, the nurses' respect for other health care professionals, and the nurses' respect for self. These dimensions of respect flavor the cooperative relationships of the collaborating nurse:

> I'd say collaborative with an equal respect. Like it wasn't that I'm a doctor, I'm a nurse, I'm a technician, I know better than you and I know more than you, because really that isn't true. They only know better than me and more than me in this particular environment. Well then, I know how I feel [A.2.51.1205-1213].

While enacting the collaborating role, the nurse forms cooperative relationships with clients. These relationships are marked by the nurse focusing on the situation, not assuming a position of superiority, and by demonstrating several behaviors which define the cooperative nature of the relationship: not making demands on clients, remembering clients by their names rather than their health concern, not being condescending in their interactions with clients, recognizing the clients' expertise, and not attempting to take power or control from the client.

> I was the person worthy of attention. I felt a sense of power and self control, that is, they weren't trying to pull it from me because 'They knew best', quote unquote. They -- we all knew best [A.2.36.847-850].

Rushing and being dishonest were the two primary manifestations of the nurse being condescending with clients. When the nature of the nurses' relationship with the client is cooperative, "taking time" to ensure the client is part of the process encourages the clients' cooperation, expresses compassion, and is a way to achieve quality or a better client-centered health outcome. Truthtelling and honesty are manifestations of the cooperative relationship between client and nurse, and are enacted through information-sharing, answering questions, "knowing where things are at" (literally and figuratively), and listening. Within the cooperative relationship, the nurse shares preliminary screening results in such a manner that as much information as possible is shared as soon as possible without falsely leading the client. The nurse attempts to be reassuring, recognizing clients need to know what to expect and what is expected of them, as soon as possible:

> She was very careful [in what she said]. And yet, she knew I needed reassurance or else I would be berserk for yet another week [A.1.22.1033-1035].

Within the cooperative relationship with the client, which is based on respect, the nurse balances the client's need for information and reduction of emotional discomfort, against the withholding of information, until final results are available. This balancing is a manifestation of the cooperative relationship, and the nurse's enactment of the collaborating role.

Listening, in a "feeling" way, is also a part of the cooperative relationship between client and nurse. Though similar to listening in the caring role, the motivation is different

in the collaborating role: within the domain of working with the client, the nurse listens to the feelings as an extension of giving more time, not being condescending, and as an expression of respect for the client. When the nurse is truly collaborating with the client, within a cooperative relationship, listening is a manifestation of equality, respect, and recognition of professional limitations. As well, the nurse listens in a "feeling" way in order to identify opportunities to give reassurance and information which will reduce emotional discomfort, much the same as in the caring role.

The nurses' respect for other health care professionals, combined with a client-centered focus or putting the client first, is the foundation for cooperative relationships with peers:

> They've got to be able to work with their own peers, in a collaborative way, rather than in a competitive way so that they can do the largest good [A.3.10.228-230].

The nurse demonstrates specific behaviors that define the cooperative nature of the relationship with colleagues, which are similar to those behaviors that define the relationship with the client: information-sharing, listening, maintaining the appearance of order, and being decisive. Information-sharing within the domain of working with colleagues involves leading and teaching in multi-disciplinary conferences, speaking up when information about the client is known which might be beneficial to others, and providing expert professional opinion. Listening, another significant behavior related to cooperative relationships with colleagues, involves the nurse listening critically and analytically to comments from others, for an opportunity to learn as well as identify opportunities for sharing information and knowledge about the client. In maintaining the appearance of order within the domain of working with colleagues, the nurse not only

organizes and coordinates the activities of others, but ensures this is visible to the client. The client is reassured that someone is in control, managing the process, being decisive, and being the patients' advocate. Clients believed that nurses were engaging in this information-sharing, listening, maintaining the appearance of order, and being decisive since it was obvious to them that the nurse was "running the show". Informants indicated how grateful they were that they didn't need to be so vigilant since someone who was knowledgeable was providing leadership. This patient advocacy is dependent upon the nurses' self-respect, confidence, and leadership qualities.

The nurses' respect for self involves a valuing of self and recognition of individual expertise:

> I got the feeling that academic knowledge, their knowledge and their skills were highly prized. They felt proud of their own skills and knowledge, each of them. They respected that in others [A.2.29.679-682].

Given this foundation of knowledge, the nurse provides leadership to the health promoting process and acts as the patient's advocate, which is a critical component of the collaborating role.

> If there was someone who was insecure in the position, for example that [nurse] had or has, I wouldn't have a lot of confidence in that person to know what in the world was going to happen to me, or that a change could be effected on my behalf --to my benefit. I need someone who's got some self-esteem and some confidence and behaves as a leader would, with a knowledge base [A.3.21.515-522]..

Knowing the limits of her professional expertise, which determines when to refer, the nurse does so in a manner which builds the client's confidence in the referred-to health care professional(s):

> I think when the nurse is working independently, she has to be aware of the limits of her involvement. She isn't a doctor, and she isn't an X-ray technician, and she

> isn't a lab technician, so she needs to be aware of the limits of her professional responsibility. So if something is beyond the scope of her experience or the scope of her training or the scope of her... What's the word I'm looking for? The person who can best meet that particular need at that particular time [C.3.20.567-571].
>
> Knowing when to refer. Humility might be the word. You realize that as a nurse that's as far as you can go and you still have the patients' well-being at hand; uppermost, and so you need to turn them over to someone else, for this particular need. Not that you are abdicating all responsibility. It's just that this particular need is beyond the scope of your professional involvement [C.3.21.599-606].
>
> One day they had to refer me off to another doctor, because of a conference, and they spoke highly of him. They were as a team [D.1.23.557-561].

Enactment of the collaborating role primarily involves being in relationship with others in a cooperative manner. The nurses' motivation is grounded in respect: for self and others. The nurse enacts the collaborating role within the domain of working independently, as well as within the domain of working with other health care professionals.

Communicating/Health Resource Role

Though presented last in the findings, it is the health resource role which is considered *the* role of the professional nurse in the health promotive setting. Enactment of the health resource role is the work of the nurse in the health promotive setting, and primarily involves meeting the clients' needs. This role exists within the domain of the nurse working independently, as well as within the domain of working with other health care professionals.

Of the four roles of the professional nurse in the health promotive setting, it is the nurse in the role of health resource which is sought out by clients. Informants indicated that need is the reason for seeking out the nurse:

> I see them as people with whom I cooperate when I have that need. It's just an inextricable relationship, except when we don't need each other. I mean it's based on need [A.3.4.84-92].

Client need is primarily emotional in nature, and is described by informants as "crashing and burning" [A.1.3.96], "not being wrapped too tightly" [C.1.14.311], "not feeling too put together" [C.1.4.87], "couldn't cope" [E.2.3.69], and "emotionally panicking" [A.1.13.610]. In some instances, emotional need and physical need are present at the same time. Informants view physical need as a legitimate reason for seeing a nurse, and often the factor which sways their decision to seek out a nurse versus an alternative kind of health care professional:

> I identified the fact that I needed medical information, as well as emotional support. Had it been just emotional support, then I don't know whether I would have come to a nurse or whether I would have sought out a psychologist [C.3.17.463-466].

In the health resource role, the nurse meets the clients' needs, reduces feelings of vulnerability, and brings stability to the clients' situation. The primary means of the nurse doing this is through information sharing or being a health resource:

> I mainly was looking for information and I got it. She was very knowledgeable, and she had the specific information that I was looking for [C.1.4.84-85].

Information sharing in this role is a distinct recognizable expert nursing skill. As a health resource, the nurse learns from the experiences of countless other clients, what exactly clients "need". That is, the nurse draws from the similar experiences of others such that she knows what clients need, even when they don't know what they need. It appears that what they need is information on how to deal with health issues:

> They want to be helpful but it's almost like, "You tell me how I can help you", kind of thing. And, at that point I didn't need that. I needed to be told what kind of help I needed [C.1.23.500-502].

> She offered information that I didn't have to ask necessarily, [otherwise] how would I know? And that was reassuring [A.2.41.969-971].

The nurses' expertise has been developed in terms of not only knowing *what* is going to be helpful to the client, but also knowing that *too much* information at the *wrong time* will not be helpful to the client. As a health resource, the nurse knows which information to give, and is sensitive to timing:

> She gave me just the information that I needed, because of the experience that she had. She really knew what I needed to know at this point in time, and didn't overwhelm me with too much information [C.2.7.174-176].

> They were being calm. They were putting themselves in my position, telling me what maybe they would want to know and also telling me all that they knew about the situation, from their past experience [B.2b.13.325-327].

This expertise in information-sharing, is developed through the nurses' skill in gathering information from clients, that is, listening and being open to what clients have to say:

> I don't think [nurse] only listened to me to answer questions, I'm sure that she drew upon what I was experiencing so that she could pass it on to other people [D.1.25.601-603].

> I felt that they were experienced, so that they could share other women's experiences [D.1.15.366-367].

The nurse as health resource offers the experiences of other clients and what they found helpful, as a means by which to initiate and continue an assessment of the present clients' needs. This assessment occurs primarily through information sharing and listening: a process involving *turn-taking* between nurse and client. One client identified this back and forth movement between information sharing and listening, as "pacing":

> She can develop those skills of giving information and accepting information and so on, with openness. She develops the skill of pacing. Pacing just how much she needs to input in order to get some feedback [C.2.14.359-362].

The purpose of this *turn-taking* or "pacing" is to assess the client's current knowledge level. It is grounded in the nurses' genuine positive regard for clients, and belief that clients are capable of caring for themselves. Clients see the nurses' belief in their competency, the nurses' genuine positive regard for others, and "pacing", as manifestations of her expertise. The nurse does not minimize the importance of their individual experience by saying how countless others have been through the same thing, but rather, the nurse attempts to reach a connection with them by saying that she has known other women who have found a certain strategy helpful, or identified a certain intervention as effective.

Another significant aspect of information sharing involves the nurses' honesty in sharing information, and the willingness to do so. Clients believed both of these aspects stem from the nurse being secure in her knowledge base, and clear as to what her true role is:

> They're more knowledgeable here [D.2.14.326].
>
> A feeling that they knew their jobs and they were willing to share with others, all that they knew [B.2b.14.355-356].
>
> But then she put the report down for me to actually read through. Sure, it was technical terminology, but it wasn't, 'I'm the keeper of [the] information and I'm going to share with you only what I feel I want to share' [D.1.11.271-275].

This honesty, and willingness to share information, leads to effectiveness as a health resource. Another dimension of this effectiveness as a health resource, results from the nurses' availability:

> They have a place on their own [that] you can tap in [to] for whatever needs you have: for the resources and to gather the resources [C.2.5.125-129].

Availability involves the nurse as a health resource being available in many physical locations outside the traditional doctor's offices, hospital settings, and clinics. However, availability also includes a timeliness factor. Availability means being available or accessible when the client perceives the need: this is the nurse as an effective health resource.

> But there's a need outside the hospital setting, and outside the doctor's office, and outside the clinics. I think that's where the missing link is [C.2.3.70-76].

Further, clients identify that it is through the nurse as a health resource that their needs were met. In many instances, informants identified that several attempts to have their needs met were not paid attention to by other health care professionals (that is, physicians), and this was believed to be a result of clients not being able to articulate what it was that they needed. As mentioned previously, the nurse as a health resource *knew* what the clients needed, even when the clients weren't able to say what it was that they needed. This appeared to be a distinguishing factor between the nurse in the health resource role, and other health care professionals.

Informants believed that an outcome of the nurse being an effective health resource, was their empowerment or control:

> I don't know what I would have done if I had not been able to come here and get the information. The information gave me control again, or gave me a bit of power [C.1.7.145-147].

> To me, that gives me power, the knowledge, the information, the general knowledge I guess is the only word I can think of. The awareness, the knowing that these things [recurring breast lumps] are there. You don't have to dwell on them. You don't even have to look for them, but just be aware that they may happen. To me, that's power, that's knowledge, a kind of control [C.1.13.290-294].

[Clients] become empowered through positive interactions [D.1.18.444-445].

As well, informants indicated that the result of their experience was a new level of expectations regarding any future interactions with nurses. Informants believed that they now knew what was possible and reasonable.

In contrast to the positive outcomes of their experiences, informants hypothetically identified what would have happened if the nurse had not been an effective health resource to them:

> And I probably would have walked out of wherever I was. I would have left [C.2.8.201-203].

Informants identified that the nature of their first encounter determined whether or not they would view the nurse as an effective health resource available for accessing again in the future. The primary reason for this appears to be the informants' vulnerable status, and the notion that they approached the relationship with the nurse, as one of trust:

> I felt very vulnerable and not too well put together [C.1.5.106].

> Telling the truth, you know, was the remarkable thing. I think that's a really critical issue here. Tell the truth and if you don't know the truth, then say you don't know it and go find out. And if there's no way of knowing, then say that. She didn't do any of that condescending stuff. I probably would have walked. I probably would have left [A.2.40.940-945].

Another aspect of the nurses' effectiveness in the health resource role exists within the domain of the nurse working with other health care professionals. As a health resource, the nurse conveys information to other health care professionals in a way that it is heard:

> She has to be astute in conveying information that she knows from her contact with the patient, to the other team members. I think she has to be astute knowing how to relate the information so that it won't be sort of assumed or taken by the

> other team members that she's the know-it-all and she knows everything. [That] everything she says is absolutely right, and perfect. Because the other team members, if they have contact with the patient, which they should, have their own sort of opinions and ideas of how to best care for that patient. This way she'll be more effective, or effective as possible, considering that the patient is supposedly the focus of the teams' efforts. For the health of the patient [C.3.19.533-542].

The effective conveying of information to other health care professionals is grounded in 'putting the client first'. Specifically, the nurse modifies her communication style so that others will hear her rather than be threatened by her. Informants believed this communication style was manifested in the following behaviors: being approachable, not being overpowering, not being overbearing, and not being overwhelming, but rather focusing on what is best for the client.

The final element of effectiveness of the nurse in the health resource role relates to the notion that having nurses who are effective health resources is not by chance. Deliberate and skillful selection of appropriate individuals to fill the role leads to effective nurse health resources:

> Whomever has done the hiring, however they gone about doing that, they've done a really good job [D.1.24.574-576].

This selection process appears to be the result of a belief held within the setting, which one informant described as a belief in "the strength of yourself and the people that you're working for: the patients" [A.3.37.911-912]. Informants believed that skilled, knowledgeable nurses were selected while keeping in mind that clients are capable and equal partners in the health promoting setting. One informant believes it stems from a desire to have humanizing connections between clients and nurses, and that certain kinds of nurses are required to ensure these humanizing connections.

The role of the professional nurse in the health promotive setting was identified and verified by the informants. The professional role formed the foundation for four distinct roles of the professional nurse in the health promotive setting. While the health resource role comprises *the* work of the nurse in this setting, it is through enactment of the collaborating role that the nurse creates cooperative relationships. For these informants, the nurse ministers to the psyche of the client and focuses on the present, within the caring role, while a future orientation and focus on the health goals of clients, marks the uniqueness of the health advocating role.

Themes

The last group of findings arising from this investigation, involves the identification of three major themes, briefly stated as follows: (1) rushing, or not making time or taking time or giving time, are informal techniques of social control, which relate to client-nurse relationships of inequality in the health promotive setting, (2) sharing information and knowledge are a means to share power and control in the health promotive setting, and (3) personal power and control lead to feelings of empowerment and responsibility, on the part of clients. These themes assist us in understanding the "meanings" of the client's experiences in the health promotive setting. What follows is a brief summary of each of these themes.

The theme of time is repeated throughout the transcripts and occurs within each of the roles. There is this notion that time, or the making or taking of it, on the part of the nurse, is linked to whether or not the client will be in a passive position versus one of equality in relation to the nurse. The idea that if time is taken, or if the client is not rushed, the

client and nurse engage in a "doing with" relationship, rather than a "doing to" (passive), or "doing for" (unequal) relationship. Within the time theme, the notion that "time" is within the nurse's realm of control, and is, in fact, her choice is evident. Implicit in this, is the idea that the nurse decides or determines whether the nature of the client-nurse relationship will be an equal partnership or an unequal "unprofessional" relationship. Stated another way, there seems to be the idea that time within the client-nurse relationship (a relationship which was established by the client, rooted in a desire to re-gain perceived loss of control), is a major factor in determining whether or not clients achieve their goals, or instead, experience an even greater sense of loss of control.

The second theme throughout the data, is related to the idea of knowledge and information being a means to power and control. The nurses' knowledge and information-sharing clearly placed them as experts, working in partnership with clients. The notion that knowledge and information was a 'sharing between' nurse and client, resulting from the nurse's decision to do so, also seemed to be a recurring sentiment in the data. Implicit in this sharing of knowledge and information between client and nurse is the notion that, the nurse is 'doing with' the client, not 'doing for' or 'doing to' the client. The relationship is equal in nature.

The third theme within the data, relates to the notion that power and control leads to feelings of empowerment and responsibility. If the themes are viewed consecutively, it would seem that taking time is a factor which somehow relates to the creation of an opportunity for honest dialogue, in a relationship of equality between client and nurse. Through effective dialogue (pacing or turn-taking), within the context of an equality

based relationship, knowledge and information is shared between nurse and client (partnership). This somehow seems to be connected to a sense of control and power within the client (self-efficacy or empowerment).

These three themes are clues to the meanings these nurse-client encounters held for informants in this setting: the meaning of professional, the meaning of time, the meaning of shared knowledge, and the meaning of power and control. Though additional theme identification within the data is possible, it is not within the scope of this thesis to do a comprehensive identification and synthesis.

The roles of the professional nurse in the health promotive setting, and the themes evident within the attributes of these roles, results in what this investigator believes to be the central finding in this study: the role of the professional nurse in a health promotive setting is to form a collaborative, partnership relationship with the client, based on equality, which will result in client goal attainment (a regaining of control and power) through the nurse sharing expert knowledge. The significance of these findings will be discussed in the following section.

CHAPTER V

Discussion

This chapter is divided into four sections. In the first section, an overview of health promotion literature will be presented with the findings. Analysis of the study data gave rise to a need for the investigator to conduct a broader search of the literature encompassing the areas of health promotion, health promotion models, and health professional roles in the health promotion process. A condensed review of the literature will be provided as a foundation for critiquing and discussing the study findings, which will immediately follow in the same section. Secondly, in view of the findings, recommendations and implications for nursing research, education, and practice will be presented, including a summary of the anticipated influence of the findings on the investigator's practice. Thirdly, a critique of the study methods will be presented. Lastly, a summary and conclusion are provided.

Critique of the Findings

From the findings of this study, it is suggested that within the health promotion setting, nurses: (1) are viewed as true professionals, (2) fill four roles, those of caring, health promoting/health advocating, collaborating/client advocating, and health resource/communicating, (3) establish collaborative partnerships with clients, (4) share expert information and knowledge with clients, and (5) facilitate client goal attainment (restoration of power and control) through collaborative partnerships and information sharing.

The purpose of this section is to discuss and critique the findings of this study as they relate to the existing work on the role of the professional nurse in health promotion. Since the literature discussed in Chapter II primarily focused on caring, while findings presented in Chapter IV focused on client-nurse interaction factors (nurse roles) in health promotive settings, a brief presentation of the literature on health promotion might best precede the critique of findings. Health promotion literature is presented in the following order: (1) a brief history of health promotion, (2) the development, evolution, and testing of health promotion models external and internal to nursing, highlighting the point at which client-nurse interactions factors were included into these models, and finally, (3) a discussion of this study's findings.

Historical Review

The Biomedical Approach - Prior to 1970

> In Ancient Greece, the birth place of western medicine, Aesclypius the surgeon healer was flanked somewhat subserviently by the two nurses of health, Hygeia, the goddess of hygiene, prevention, good water, and good food, and Panacea, the goddess of nostrums and cures. Apart from the sexists healing roles this presentation evokes (male as surgeon-"hero," female as nurse-"nurturer"), the ages'-old tug of priorities between health promotion (Hygeia) and disease treatment (Aesclypius) stands starkly. Hygeia herself was lesser ranked than her cure-all sister.
>
> (Labonte, 1993)

From Ancient Greece until the early 1970s, health was defined in terms of the absence of disease, in an environment in which the body was conceived of as a complex machine requiring repairs when stricken by disease. Although the World Health Organization challenged this view of health nearly fifty years ago, claiming that health "represented a state of complete physical, mental and social well-being" (as cited in Labonte, 1993),

most health care agencies and organizations continued to focus on the treatment of disease and viewed health promotion as disease prevention, since a means to obtain such a broad, subjective notion of health was unclear. Leavell and Clark (1965), contributed to the refinement of ideas of health promotion by proposing that health protection included disease prevention (avoidance strategies) and health promotion (approach strategies). They described and defined primary, secondary, and tertiary prevention: primary prevention is the provision of specific protection against disease to prevent its occurrence; secondary prevention consists of organized screening efforts or public education to promote early case findings of individuals with disease; and tertiary prevention begins early in the period of illness recovery to prevent long-standing complications (Pender, 1987).

Psycho-Behavioral Approach 1970-1980

In 1974 , A New Perspective on the Health of Canadians was introduced by Marc Lalonde, Canada's Minister of Health, which included the concepts of human biology, environment, lifestyle, and health care organization within its conceptualizations of health. This paper stressed the importance of the individual in determining health status. The focus on risk factors and individual management of these factors moved health beyond the disease prevention spectrum to include notions of promoting physical well-being or healthy lifestyles. In 1977, the motto, "Health For All By the Year 2000" was adopted by the World Health Organization (WHO, 1977). This marked the transition of conceptualizing health as primarily the responsibility of the individual, to one of health being contingent upon dimensions of global equity in distribution and accessibility.

The Socioenvironmental Approach 1980 - Present

In 1986, the Minister of National Health and Welfare, Jake Epp, released "Achieving Health for All: A Framework for Health Promotion", which became known as the Ottawa Charter for Health Promotion (International Conference on Health Promotion, 1986). Within this document, Epp defined health promotion as "the process of enabling people to increase control over, and improve, their health". The prerequisites to health were expanded to include peace, shelter, education, food, income, a stable ecosystem, social justice, and equity.

To summarize, the major trends in the approaches to health promotion can be viewed as: (1) from absolute sickness or health to relative health, (2) from individual responsibility to societal responsibility, and (3) from unidimensional focus to holistic focus (King, 1994). Health promotion is now recognized as a complex concept involving a blend of attitudes, behaviors, and knowledge related to health.

Health Promotion Models

Varying trends in health promotion approaches precipitated the development of various models to provide a framework for investigation of these approaches, and to build health promotion knowledge. As early as 1950, Rosenstock developed the Health Belief Model to provide a framework to investigate why some people who were disease free took action to avoid disease, while others did not. The model has a psychological perspective, and holds motivation as its central concept. It was followed shortly by the Suchman Model (1966), embedded in a sociological perspective, which combines individual variables with sociocultural variables to explain client health behavior. Neither

of these models addressed the client-professional interaction as a factor in health promotion.

In Kulbok's (1983) analysis of the research using these various models from 1950 through 1980, she notes that the focus is largely on why people used disease preventative behaviors. This disease preventative focus is congruent with the biomedical origins of health conceptualizations. Although Leavell and Clark (1965) had a lasting influence on how health promotion was viewed, largely as a result of their work in defining the levels of primary, secondary, and tertiary disease prevention, Pender (1984) notes that during the period of 1970 through 1982, nurses did not clarify definitions of health behavior with respect to disease prevention or health promotion.

The Interaction Model of Client Health Behavior was proposed by Cox in 1982, resulting from a recognition that existing models were disease prevention focused, emphasizing the behavioral, psychological, sociocultural component of client health behavior. Cox noted a marked absence of attention to client-nurse interactions. Moreover, where previous models with biomedical origins were best suited to deal with research questions of a disease prevention nature, Cox's model truly changed the focus to health promotion. In her model, health promotion behavior is defined in a global sense as practices which enhance or sustain a client's well-being. The model is organized by three major components: client singularity, client-professional interaction, and health outcome. The introduction of a client-professional interaction component was perhaps the first attempt at creating relevance and value for the practicing nurse, by offering a framework for the investigation of how clinicians could best intervene in health promotion settings.

In 1982, Pender proposed the Health Promotion Model, and refined it in 1987. She conceptualized health promoting behavior as an expression of the human actualizing tendency, and health protection behavior as human stabilizing tendencies. This model defines certain cognitive-perceptual factors as being major determinants of health promoting behavior: importance of health , perceived control of health, perceived self-efficacy, definition of health, perceived health status and perceived benefits of and barriers to health promoting behavior. In addition, there are specific modifying factors: biological characteristics, situational factors, interpersonal influences, and behavioral factors, which have a role in health promoting behavior. Interpersonal influences would encompass client-nurse interaction factors.

Simmons (1990), in an effort to integrate the perspectives of self-care with health promotion, proposed the Health Promoting Self-Care System Model which integrates Cox's (1982) Interaction Model of Client Health Behavior, Orem's (1985) Self- Care Deficit Nursing Theory and Pender's (1982,1987) Health Promotion Model. The model was intended conceptually to integrate self-care and individual health promotion perspectives in order to explain more precisely the hypothesized relationships among factors believed to influence the decision-making, performance, and outcomes of health promoting lifestyles. The nursing system/supportive educative component is equivalent to Orem's (1985) supportive-educative nursing system, Cox's (1982) client-professional interaction component, and Pender's (1987) interpersonal influences component, and includes the following elements: health information, affective support, advocacy in client

choices, and technical intervention when necessary. Simmons encourages further testing of the Health Promoting Self-Care System Model.

In each of the models developed by Cox (1982), Pender (1982, 1987), and Simmons (1990), there is identification of a component and corresponding elements which recognize client-nurse factors as influencing health promotion. Within all the health promotion models, overall determinants of health promotive behaviors are proposed as individual cognitive-perceptual factors, modifying factors, and direct cues to action. The individual cognitive-perceptual or client singularity factors have been studied extensively using all models (Brown, 1992; Brown, Muhlenkamp, Fox, & Osborn, 1983; Cox, Cowell, Marion, & Miller, 1990; Cox, Miller, & Mull, 1987; Cox & Roghmann, 1984; Cox, Sullivan, & Roghmann, 1983; Cox & Wachs, 1985; Cox, 1985, 1986; Duffy, 1988; Farrand & Cox, 1993; Kulbok, Earls, & Montogmery, 1988; Laffrey & Isenberg, 1983; Locke & Vincent, 1995; Lusk, Ronis, Kerr, & Atwood, 1994; MacDonald, Laing, & Faulkner, 1994; Pender & Pender, 1986; Riccio-Howe, 1991; Troumbley & Lenz, 1992; Wallston, Maides, & Wallston, 1976). The modifying factors (which include client-nurse interactions) have not been sufficiently studied to allow the development of prescriptive nursing practices in health promotion settings (Brown, 1992; Cox & Roghmann, 1984; Cox, Sullivan, & Roghmann, 1983; Lindsey & Hartrick, 1996; Hartrick, Lindsey, & Hills, 1994; and Sidney & Shephard, 1976). Palank (1991) suggests that until further research is conducted on both of these factors individually, as well as combined, nursing implications remain theoretical.

Three integrative reviews collectively provide a comprehensive treatment as to the nature of nursing studies of health promotion behaviors from 1981 to 1995, the conceptual frameworks utilized, and health outcomes studied (Carter & Kulbok, 1995; Gillis, 1993; Kulbok & Baldwin, 1992). To summarize the findings reported in these works: (1) Pender's Health Promotion Model (1987) is the most widely used conceptual framework, with considerable recent investigation into Cox's Interaction Model of Client Health Behavior, (2) client singularity factors have been studied far more than client-professional interaction factors, although the specific client singularity factors studied have not necessarily been those most reflective of health promotion behaviors, and (3) of the factors studied, self-efficacy is the strongest predictor of health promotion lifestyles, however, health promotion behaviors and lifestyles have been predominantly operationalized as medically recommended health practices versus well-being or eudamonistic models of health.

Using Carter and Kulbok's (1995) suggested framework for organizing the nursing activities which have relevance in client-nurse interactions into four main categories, I reviewed and classified located literature as follows: (1) provision of health information (Brown, 1992; Cox, Sullivan, Roghmann, 1983; Lindsey & Hartrick, 1996; Hartrick, Lindsey, & Hills, 1994; and Sidney & Shephard, 1976), (2) affective support (Brown, 1992), (3) decisional control (Brown, 1992; Cox & Roghmann, 1984; Lindsey & Hartrick, 1996; Hartrick, Lindsey, & Hills, 1994) and (4) professional-technical competencies (Brown, 1992; Cox & Roghmann, 1984). As is evident here, there was limited research which focused on client-nurse interactions.

The four areas described by Carter and Kulbok are consistent with three of the four roles arising from findings in this study: (1) the Health Resource/ Communicating Role [primarily involving provision of health information], (2) the Caring Role [primarily involving the provision of affective support], and (3) the Collaborating/ Client Advocating Role [primarily involving aspects of decisional control]. The fourth nursing activity area identified as influencing client-nurse interactions, by Carter and Kulbok, is professional-technical competence. Professional and technical competence are reported in this study, as part of both the Collaborating/ Client Advocating Role and the Health Resource/ Communicating Role. However, these aspects of competence are not the essence of the fourth role (Health Promoting/ Health Advocating) identified in this study. The following section will discuss these findings as they relate to what has been presented in the truncated review of the health promotion literature. The section will conclude with observations as to how these findings may be used to extend knowledge in nursing practice, education, and research.

Discussion of the Findings

Caring Role

In the Caring Role, as identified in this study, the nurse is primarily concerned with ministering to the psyche of the client. Ability to enact this role is embedded in the nurse's capacity to be genuine, authentic, and caring. This is consistent with the literature by Roach (1987) and Watson (1985b), in which authenticity and presence are integral to caring. Although the investigator could find little descriptive or investigative literature regarding caring in the health promotion arena, Labonte (1993) suggests that it is, in fact,

necessary in the context of health promotion. Labonte does not refer to presence in his discussion of caring, but he does assert that focusing on the individual and the immediate and personal concerns of clients is our only means of preventing the rendering of social concerns as personal problems. He suggests that victim blaming is the result of an absence of caring, acceptance, and positive regard in health promotion settings.

Brown (1992), in attempting to empirically validate the "individualization of care" concept suggested by Cox in the Interaction Model of Client Health Behavior (1982), reported that the "tailoring, fitting, or matching" of interactional nursing approaches to client's singularity by expert nurses resulted in the client's emotional state (actual or likely) being attended to. Although the interactional nursing approaches are described as nursing care, as opposed to caring, the comfort and support behaviors described are similar to two of the constructs Leininger describes in her taxonomy of caring (1981). Brown's findings suggest that individualization of nursing care is related to the "joint endeavor" nature of the client-nurse interaction, and that caring is a result of the nature of the relationship.

The notion of team work being part of caring has been reported previously by Schaefer and Lucke (1990), in their descriptions of the clinical nurse specialist's caring role. In their view, the role comprises six distinct components: investigating, teaching, creating-the-new, showing-the-way, working-with-others, and taking-care-of-the-environment, all within the context of caring. In their study, working-with-others encompassed the notion of "team work" which the investigators suggest leads to mutual goal definition and makes

explicit which caring activities need to be performed. Unlike the findings in this study, Schaefer and Lucke do not suggest that the client is a member of the team.

When comparing the caring role as defined in this study, with Leininger's (1981) caring constructs (as detailed on page 6 of this document), some similarities are noted. Most notably, Leininger's constructs of presence and touching were described within the caring role sub-segregates of this study as "being attentive", "being present-oriented", and "using touch".

The other substantiative body of work which can be explored for comparative purposes is that of Watson (1979). Notably, Watson has based her theory of scientific and humanistic caring on several assumptions, one of which is that: "effective caring results in health promotion and individual or family growth". Clearly, Watson believes a relationship exists between health promotion and caring. When comparing Watson's ten carative factors with findings about the caring role in this study, consistency is found with three factors. Specifically, Watson's "cultivation of sensitivity to self and others" is similar to "attentiveness and self-awareness of the nurse". Watson identifies the promotion of interpersonal teaching and learning as another carative factor, which is consistent with the information sharing component of the caring role reported in this study. Finally, Watson's carative factor of assistance with human need gratification closely resembles the touch, positive regard, and acceptance of clients elements of the caring role in this study.

Health Promoting/ Health Advocating Role

The findings of this study resulted in the identification of a Health Promoting/ Health Advocating Role for nurses in the health promoting setting. It is implicit in the health promotion literature that the nurse has a role in health promotion settings, however, specific activities or behaviors which demonstrate health promotion role enactment are poorly documented.

In this study, the Health Promoting/ Health Advocating Role primarily involves the instruction of clients in their responsibilities in the health process. The nurse focuses on the client's future health using a positive, proactive, holistic approach, building on what is right at the moment, and assisting the client to move toward improvement. This overall view of health promotion as holistic and positive in nature supports Kulbok and Baldwin's (1992) assertion that high level wellness and self-actualization processes must be emphasized by nurses in health promotion arenas.

Hartrick, Lindsey, and Hills (1994) proposed a health-promoting assessment framework for use in working with families. In a later work (1996), Lindsey and Hartrick suggest the health promoting assessment framework is, in fact, a Health Promotion Process suitable for validation in all settings. This process comprises: (1) listening to the client, (2) participatory dialogue, (3) pattern recognition, and (4) envisioning action and positive change. Listening to the client involves engagement of the client in order to understand the client's meaning of health and healing experiences. This leads to participatory dialogue or critical questioning in order to raise the client's consciousness about facilitating and constraining factors which may be influencing the situation. In turn,

the client is able to move from the present circumstances to a future perspective. The participatory or critical dialogue allows clients to recognize patterns and themes in their health experience and healing practices, and envision future action and positive change. This problem-posing process (versus problem-solving process), on the part of the nurse, moves away from focusing on the client's deficits to focusing or resourcing the client's potential. The health promotion process is viewed as a collaborative endeavor between client and nurse working in an egalitarian relationship. It is a client-driven model exemplified by the nurse facilitating the client's own potential, with the client being the expert.

The similarities between Lindsey and Hartrick's (1996) health promotion process, and the elements of the Health Promoting/Health Advocating Role, are apparent. Although my findings did not lead to the uncovering of a health promotion process per se, study findings were indicative of "positive steps" or activities through which nurses assisted clients. Participants did, in fact, use the word process. It may be due to the inadequacy of ethnography and ethnoscience for effectively dealing with process data that this potential process embedded in the Health Promoting/ Health Advocating Role was not discerned. Grounded theory may have provided a means to think about this data differently. In retrospect, it is clear that subjects spoke of "steps" spanning "multiple settings", which may have been describing *how* nurses promote health or the role of the nurse as she/he guides the client through the *health promotion process.* These findings do offer some support to existence of the health promotion process as described by Lindsey and Hartrick (1996), with the major difference being the word "expert" was used in this study

with reference to nurses, while Lindsey and Hartrick used the word in reference to patients.

Collaborating/Client Advocating Role

In this study, the Collaborating/ Client Advocating Role involves the nurse's establishment of relationships of a cooperative nature, which arise from the nurse's respect for self and others, and a willingness to focus on the client. In this study collaborating is recognized by cooperative relationships between nurses and others (including patients), not attempting to take power or control, and information-sharing.

In this study, subjects reported collaboration and cooperation as critical elements in health promotion relationships. These findings are supportive of the work of others, particularly with respect to decision-making (Brown, 1992; Cox & Roghmann, 1984; Hartrick & Lindsey, 1996; Lindsey, Hartrick, & Hills, 1994). There are however, findings suggestive of nurses' general over-estimates of client's needs for collaboration (Kim et al. 1993), or with collaboration arising from the health care providers' desire to curtail costs (Waterworth & Luker, 1990), and the patients' desire to "toe-the-line" (Waterworth & Luker). The assertions of these latter investigators are not supported by the findings in this study.

Another significant element of the Collaborating/Client Advocating Role, obvious by its inclusion in the role title, is client advocacy. Generally, client advocacy in nursing is concerned with informing and supporting a person so he or she can make the best decisions possible. Spellbring (1991) defines the effective advocacy role as: (1) being assertive to help clients meet their needs, (2) willing to take risks for clients, (3)

communicating well, to state client concerns and to work toward resolution, and (4) identifying the power bases and working the system to facilitate change on the clients' behalf. These criteria are consistent with the findings in this study, in which the Collaborating/ Client Advocating Role is characterized as the nurse providing leadership, being in control, communicating with colleagues on behalf of the client in a manner in which comments are heard, and knowing when to refer.

Labonte (1993) distinguishes the difference between "advocacy for" (representing the weight of professional status applied on behalf of the client), and "advocacy with" (representing the health care professional's willingness to support clients in exercising their own voices), in health promotion settings. Labonte argues that in order to operationalize advocacy in a manner which is not paternalistic or objectifying for the client, health care professionals must have "advocacy with" clients. In this study, clients spoke of the nurse as being in control and managing the process so clients did not need to. Yet they clearly indicated that their relationship with the nurse was client-centered, situation-specific, and one in which the nurse worked with them. The data appear to reflect "advocacy with", but perhaps an additional dimension in which nurses in the Collaborating/ Client Advocating Role support clients in exercising their own voices, doing so in a manner in which the professional nurse's leadership and control are exercised. Perhaps nurses' professional knowledge (comprised of this leadership and control), is another dimension of "advocacy with" and is what enables collaboration as opposed to paternalistic relationships. Clearly, Labonte suggests "advocacy with" does not happen in paternalistic relationships.

The Alberta Association of Registered Nurses (1996) identifies the nurse's role as facilitating a coordinated, client-focused, interdisciplinary team approach of collaboration and cooperation among caregivers. "The Alberta Association of Registered Nurses: Position Paper on Health Promotion" (1989) further defines the nurse's roles as including client advocate, leader, consultant, facilitator, mediator, educator, and health resource, in the health promotion arena. Although the purpose of the documents is to reflect the belief of nurses about health promotion, and to provide direction for nurses to use the principles of health promotion in their practice, specific behaviors defining the enactment of each of these roles are not provided. However, this study does point to specific behaviors or attributes indicative of collaboration in health promotion: recognizing client's expertise (regardless of setting), truth-telling, being honest with information shared, being decisive, and being a leader. Additional findings are that client advocacy is closely linked to collaborative, cooperative relationships and is recognized by the nurse listening to comments of others, being vigilant, providing leadership, and knowing when to refer.

Health Resource/Communicating Role

The Health Resource/ Communicating Role comprises *the* role of the nurse in the health promotion setting. Participants identified this role as the focal role, that is, the characteristics of this role were what clients primarily sought from the nurse in the health promotion setting. It is recognized by the characteristics of the nurse sharing information, being skilled, knowledgeable, expert, listening, being open, turn-taking or pacing when gathering information, being honest, willing to share information, being available,

knowing what clients need, being trust-worthy, being non-threatening, and putting the client first.

As noted previously, client-nurse interactions have not been investigated to the degree that we know which behaviors the nurse is engaging in when promoting health. Nonetheless, as *the* role of the nurse in health promotion settings, the Health Resource/ Communicating Role has elements which resemble previously reported findings of other investigators. Arborelius, Krakau, and Bremberg (1992) identify "putting the client first" during information sharing and teaching, as a patient-centered style which demonstrates respect for clients. Clarke (1991) suggests that this "putting the client first" is a result of forming equal relationships with clients, based on respect, in which the nurse is "real". Clarke further asserts that the nature of the relationship between client and nurse leads to knowing what to share with clients. Previously, Chavasse (1992) reported the nurse's willingness to share information or expertise with clients is related to the nurse's confidence. Vancott (1993) suggests that nurses who listen attentively to client's stories or narrative statements will be able to identify the client's most pressing psychosocial concerns and needs. Elements of the Health Resource/Communicating Role in this study, provide support to this previous work of others.

Themes:

Three major themes arose from this study: (1) rushing, or not making time or taking time or giving time, are informal techniques of social control, which relate to client-nurse relationships of inequality in the health promotive setting, (2) sharing information and knowledge are a means to share power and control in the health promotive setting, and

(3) personal power and control lead to feelings of empowerment and responsibility on the part of clients. Support for these themes is evident in existing literature, as follows.

Health promotion relationships are noted to differ in duration and intensity, and therefore require different categories of relationships with different rules and interactional histories (Kasch, 1983). A partnership model of relationship with greater equality and reciprocity, characterized by dignity, integrity, and truthfulness is broadly accepted as the model in which ethical nursing care can flourish, irrespective of setting (Spellbring, 1991). A major theme in this study was that of the cooperative, collaborative, partnership nature of relationships within health promotion settings. The notion that both listening and the element of "time" to do so are critical elements in determining the nature of health promotion relationships is suggested in this study. The importance of listening (Honeycutt & Lowe-Worobey, 1987; Pepler & Lynch, 1991; Vancott, 1993), taking time (Pauly, 1993; Way, 1991), and their connection to the nurse attending to the client in effective relationships (Bottorff & Morse, 1994), have been reported previously. Pepler and Lynch (1991) posit that considerable skill on the part of the health care professional is required in the communication process. Effectiveness of the nurse is dependent upon recognition of the patient's desires, availability of the necessary information for the client to be in control, and readiness of the health care professional to take or relinquish control (Pepler and Lynch, 1991). Nurses are considered powerful by virtue of their expertise (Chavasse, 1992), and are in a position to share power and control with their clients. This sharing of power and control primarily occurs through the sharing of information and through specific approaches to decision-making. Labonte (1993), suggests that

empowerment means bestowing power on others (an enabling act), in which power is shared with others. It casts the act as an inherently relational event between two or more persons such that the relationship tends toward equity and fairness. However, empowerment in this transitive form objectifies the client as the recipient of power. The solution is viewing empowerment through its intransitive meaning: the act of gaining or assuming power, which makes power reflexive in that it takes no object. Labonte (1993) indicates that we will be able to recognize intransitive empowerment by the resulting improved self-esteem of clients, improved ability to reflect critically and solve-problems, improved ability to make choices, improved self-discipline, and improved ability to work with others. At the interpersonal level, "it is the experience of a potent sense of self, something that enhances self-esteem and self-efficacy; it is 'power within', the experience of choice" (Labonte, p.57). Gibson (1991), suggests "the real issue is not so much having more power, but feeling more powerful"(p.354). This sentiment was evident in the recurring themes in this study. Malin and Teasdale (1991), assert that empowerment involves a partnership between client and nurse, while Donaldson and Crowley (1978) suggest the focus of concern for nursing is the processes by which positive changes in health status occur.

Findings in this study are suggestive of cooperative, collaborative relationships in which the sharing of information and knowledge with clients leading to a sense of personal power and control are related to health status and health outcomes. Finally, Kulbok and Baldwin's (1992) assertion that nursing investigators work toward "models of health which describe exuberant well-being, becoming, and growing, with a view of

health promotion as fostering an individual's control and social responsibility" (p.59), is evident in the subjects' conceptualizations of health promotion as movement toward a positive, holistic goal.

Critique of the Methods

Methods

The purpose of this study was to examine clients' perceptions of nurse caring in a health promotive setting. An inductive approach was chosen in an attempt to capture the context specific nature of caring, since reference to its meanings and behaviors in a health promotive setting is absent in existing literature. Focusing on clients' *perceptions,* which Pluckhan (1978) describes as attending to what has been sensed through auditory, visual, and kinesthetic modes; giving order and structure to that sensed data; and making associations or giving meaning through interpretation are a means to understand what behaviors clients consider caring in this setting, and what meaning those behaviors hold for clients. In this study, clients told me about their perceptions of the professional nurse in a health promotive setting, and the attributes or values associated with each of the four roles filled by professional nurses. Within the context of the health promotion setting, these roles of the nurse were what had meaning for the clients.

Ethnography (as suggested and conducted by Spradley, 1979), includes both traditional ethnographic methods and ethnoscience. This approach affords considerable structure combined with flexibility, and the ability to elicit feeling dimensions. Ethnoscience is a linguistic technique premised on semantic principles. As such, there were times within this study when informants experienced difficulty in finding

descriptors for knowledge of what was an integrated experience for them. Periodically, informants struggled to find the words to express their ideas to their satisfaction, or expressed frustration that the words which they used were so 'over-used' or 'misused' that they did not carry the richness of meaning which they attempted to convey. Such was the case when informants referred to 'caring' or 'professional', or when trying to identify how 'really listening' was different from 'ordinary listening'. This led to descriptive phrases in building the taxonomy. Nonetheless, ethnoscience was valuable in providing a systematic method of eliciting the cognitive aspects of implicit cultural knowledge and norms.

A limitation of ethnography and ethnoscience is the inability to deal with process data. It might be suggested that a health promotion process was embedded in the Health Promoting/ Health Advocating Role. Grounded theory may have offered the investigator a means to conceptualize potential process related data, within this role, and think about where they fit in the entire scheme.

As in any qualitative research design, the richness and detail of the data has the potential to serve as a sensitizing process to the informant's setting. It is anticipated that readers of these findings will be sensitized to the client's perceptions of professional nurses in health promotive settings. Further, qualitative research depends heavily on the interpretive skill of the investigator. As noted by Glaser (1978), even investigators of a completed study may at a later date re-analyze the data and find new interpretations yielding different theory. Although the Developmental Research Sequence was followed, and the members of the researcher's committee reviewed the development of the findings,

this does not necessarily ensure that other researchers would reach the same conclusions as this investigator.

Techniques

Interviewing

The data collection technique was ethnographic interviewing. While this proved to be an appropriate and rich source of data, in retrospect, some aspects might be changed. Informants were recruited for a maximum of four interviews averaging two hours in length. Actual interviews usually exceeded two hours and subjects appeared to have much to share. Further, extreme difficulty was experienced in recruiting informants who could commit to four interviews. Through interview proceedings, it was uncovered that informants filled as many as five roles encompassing full time worker outside the home, family caregiver of parent or spouse's parent, wife, mother, community volunteer, and student. The multiplicity of roles evident in these subjects may have been a contributing factor in participant recruitment difficulties, and may be a characteristic of this particular client population. In future studies of a similar nature, using ethnographic techniques and a sample with similar demographics, modifications to the design might include a group interview as a validation strategy in order to decrease the number of interviews required. In this study, the recruitment difficulty was addressed by terminating recruitment for full participants after the third participant had been secured. Instead, two participants were recruited to act as validation participants for one interview each. This suggestion by my thesis committee members was effective in securing two final participants.

A particularly useful strategy in the interview process was the card-sort technique, during which informants became very animated and expressed great interest. In retrospect, the time required to perform this exercise was underestimated, and it may have been more appropriate to perform this exercise over the course of two interviews. As well, the card-sorting could have occurred at a lower level of analysis (distinguishing one quality from another) in a group setting, which may have led to the development of a more precise and concise taxonomy. For example, how is "putting the client first" different than "knowing what the client needs"?

Sample

In this study, a non random sampling method was used. Although the Clinical Nurse Specialist performed the screening function, there may have been unknown or unintentional investigator bias in the selection of participants. Difficulty in recruitment of subjects led to a smaller than desired number of participants. Though data were uncovered in two major domains (that is, working with clients and working with other health care professionals) data repetition and development of a comprehensive domain was achieved only in the former domain. This was a result of the difficulty in recruiting sufficient subjects to reach data saturation. As well, such a relatively small sample size does make it possible that findings may have differed if the sample size had been larger. Since all subjects fit the same cultural group and similar socioeconomic status, differing perceptions may have been gathered if the sample had been more diversified. Chance characteristics of the small sample may have influenced the interpretation in ways that might not have been found in a larger sample.

Implications

Future Research

Several implications for future research arise from this study: (1) adjuncts to this study, (2) future areas, and (3) tangential areas. The most obvious areas of inclusion for future study are related to sample. The perceptions of health promotion nurses and study groups with ethnic, cultural, age, and socioeconomic diversity should be explored. First, nurses' perceptions of positive interactions with clients in health promotion settings are noticeably absent in the literature. Since perception is integral to meaning, and one might predict that nurses' perceptions would be at least as rich as clients', investigations in this area would add considerably to our understanding of the roles of professional nurses in health promotion settings.

The second area of inclusion is that of diversity in ethnic, cultural, socioeconomic, and age, of both clients and nurses. The findings of this study are restricted to white, middle class, middle aged women with little past exposure to the formal health care system. Literature is suggestive of considerable ethnic, cultural, socioeconomic, and age diversity in terms of perceptions and role expectations of nurses (for example, Kim et al., 1993).

Several other areas for future study can be identified from this study's findings. First, the taxonomy of kinds of roles of the professional nurse in health promotion settings needs to be confirmed. The question of whether or not a health promotion process exists should be explored using appropriate research methods. The significance or importance of one role to another, the amount of time spent in each role during an interaction, and the frequency of each behavior within a role should be explored, as does the nature of the

relationship of all these elements with client health outcomes. Comprehensive definitions of behaviors within each role, clarity between roles, and the scope of each role should be explored. Little formal research examining actual professional nurse practice in health promotion settings has been reported. As well, the validity of these behaviors as client-nurse interactional factors within existing health promotion models needs to be investigated. At present, client-nurse interactional factors are largely subject to the interpretation of the investigator, and require validation. Further, findings in the Health Promoting/ Health Advocating Role in this study were suggestive of health being conceptualized as holistic, positive, and self-actualizing. Investigation is required into what elements of this particular role enactment facilitates this humanistic view of health, which is markedly different from much of the medical model conceptualizations of health outcomes.

The final area of future study might be considered tangential areas: what is the connection between the nature of the client-nurse relationship and who is viewed as an expert: how do professional nurses in health promotion settings practice self-care and self-awareness: and what is the relationship between the nurse's years of experience, perceived self-esteem, and effective role enactment.

Nursing Practice

The most important implication for nursing practice arising from this study is the awareness of roles, and the behaviors within these roles, as a means for nurses to change professional practice. Clients clearly indicated that an interaction with a *real* professional nurse was a humanizing, empowering experience that left them positively changed. A

professional nurse is recognizable by how she practices nursing in all its dimensions (physical, emotional, and spiritual), by the time she takes, by her willingness to go beyond, and by the reciprocal nature of the encounter with the client. This professional practice is the foundation upon which nurses can learn about the roles within health promotion. Clients were clear about what their reaction would have been if they had not "got what they needed" when they sought out the nurse. The findings of this study indicate that nurses need to be aware that they may, in fact, have one opportunity to interact with a client, and make a difference toward improved health. The most critical aspect of this one interaction is the cooperative-collaborative nature of the relationship, and the client's expectation that the nurse is the expert and will work with them.

Investigator's Reflections and Practice

There are several aspects to this study that have led to changes in how I view nursing, and will undoubtedly influence how I continue to practice nursing. Continued reflection on the findings causes me to question whether informants were describing (1) roles or (2) parts of a process with specific attributes. Perhaps the Health Resource/ Communicating Role is really a communicating process with the attributes of information sharing, listening, and so on. "Roles" was the word used by the informants, however, "trust" is not an action like listening or information sharing. Another thought arising from reflection is whether or not the findings in this study are gender related. Would male nurses and both female and male informants share similar experiences or are the findings in this study reflective of positive experiences between female nurse - female client interactions only?

Others have suggested findings of a similar nature are gender related (Pauly, 1993; Way, 1991). Further investigation could address these issues.

In terms of my nursing practice, the subjects renditions of their previous dehumanizing, impersonal encounters expressed with such hurt and passion was most compelling and will not soon be forgotten. I now am sensitized to the meaning of what I have previously qualified as meaningless behaviors. Not really listening, rushing, engaging in serious discussion with clients while standing -- nursing resource limitations have made this a too frequent, guiltless element of my practice in the past. Of course I believe I have really listened "when it mattered", rushed "only when necessary", and talked with clients while standing "when it wasn't important", but the truth is clients are suggesting that "it always matters". How can I now not actively listen to clients (particularly to their bids for recognition of their emotional needs), by hearing through what is said to what is felt? I am humbled by how basic and obvious this seems. I have been considering how my practice can be organized in order to reserve rushing for crisis situations, given how its very occurrence undermines clients' confidence in their health care providers. Newman's (1994) discussion of health as expanding consciousness rings true to me here, when I think of how I see nursing care organized at a higher level, transcending the rules since "my old rules" or ways of knowing and doing no longer fit.

The other major finding in this study which has led to a change in how I view nursing, and will subsequently practice nursing, is as a result of an awareness of the violating nature of "power over", controlling, and uncollaborative relationships in health care. I believe there is a means by which I can share my expertise through intransitive

empowerment of clients, without having a "power over" relationship with them. Active listening at a feeling level, participatory dialogue, and identification of available client options, will become the basis of my application of the nursing process in the future. Clearly, there are nurses, such as those who worked in the study setting, who have this knowledge already. I see that in many ways *being*, and the nature of that being with clients is more significant than *doing*, or the accomplishment of my agenda. It is not so much that I did not know all of this before, but through the interview process and the subsequent analysis of findings, *now I feel as if I know these as truths for me.*

Nursing Education

The most significant implication arising from this study, for nursing education, is the need for interpersonal competency (a function of the nurse's capacity to escape the confines of personal perspective and to assume or construct the viewpoint of the client) to receive more attention in nursing curricula. Kasch (1983), suggests that evolution toward a more health-oriented system of care requires the nurse to possess a well developed repertoire of interpersonal skills and competencies. Kasch believes competency of the nurse is likely a function of the nurse's understanding of self and others, or personal knowledge. When nursing action is viewed in this manner, as a process of social interaction, a starting point for identifying and linking cognitive competencies with goal-oriented behavioral actions is possible. Nurses must be technically, professionally, and interpersonally competent in order to establish enabling and empowering relationships with clients.

Summary of the Study

The purpose of this study was to examine clients' perceptions of nurses' caring in a health promotion setting. It is generally agreed that caring is an important phenomenon in nursing, although the exact nature of caring is not clearly understood at present. Further, it is currently suggested that caring is context dependent, in which the nature of caring is altered by: (1) both client's and nurses's expectations and prior experiences, (2) factors influencing the coming together of nurses and clients, and (3) the environment in which the coming together occurs. In order to address the client's perceptions of caring within the context of a health promotion setting, ethnography and ethnoscience (in the tradition of Spradley, 1979), were employed in this study. A series of interviews with five clients in a health promotive setting, attached to a large urban health care centre, were the major source of data.

The findings of this study led to the identification of cooperative-collaborative, partnership relationships between clients and professional nurses as the necessary foundation for nurse role enactment of four major roles in the Health Promotion Setting: (1) Caring Role, (2) Health Promoting/ Health Advocating Role, (3) Collaborating/ Client Advocating Role, and (4) Health Resource/ Communicating Role. The professional nurse is recognized by "going beyond", the collaborative-cooperative, partnership nature of the relationship with clients, and the client's experience of feeling more powerful and in control as a result of the interaction with the nurse. Egalitarian partnerships between nurses and clients in health promotion settings are considered the only means to ethical nursing practice (Rumbold, 1993).

Previously, Carter and Kulbok (1995) have identified four major categories of activities in health promotion that were effected by the nature of the client-nurse interactions or relationships. The findings in this study are suggestive of "roles" matching three of these four major groups of activities: (1) the Caring Role focusing on affective support, (2) the Collaborating/ Client Advocating Role focusing on decisional control, and (3) the Health Resource/ Communicating Role focusing on provision of health information. The fourth area suggested by Carter and Kulbok, is that of professional-technical competence, which was found to be part of the Collaborating/ Client Advocating and Health Resource/ Communicating Roles in this study, but was not substantiated as a singular focus or role. The fourth role identified in this study, the Health Promoting/ Health Advocating Role most closely resembles the Health Promotion Process suggested by Lindsey and Hartrick (1996). It is possible that a health promotion process is embedded in this role, however, ethnographic study methods used in this study, did not reveal this. Nonetheless, Lindsey and Hartrick suggest four parts in the Health Promotion Process: (1) listening to the client, (2) participatory dialogue, (3) pattern recognition, and (4) envisioning action and change. Major elements of this suggested Health Promotion Process which were found in this study are, a focusing on positive potential, and egalitarian partnership with clients. Although many (for example, Lindsey & Hartrick, 1996; Parse, 1990) suggest the client is the expert, this study did not support these findings in this health promotion setting. Rather, it would seem the client sees expertise as context specific, and although clients were self-reported experts in many

areas, they clearly viewed the professional nurse as an expert in the health promotion setting.

Findings in this study are suggestive of cooperative-collaborative, partnership relationships in health promotion settings being the basis for effective nurse role enactment. The nature of these cooperative-collaborative relationships, and the effective enactment of the four roles, in turn, effects a positive health outcome with clients. Descriptions of the four roles begin to inform us of what nurses are doing when they are engaged in health promotion activities.

Little previous work exists in terms of examining the client-nurse interaction factors in health promotion models. Pender's (1987) model has been the most widely tested, however, the client-interactional factors are the least explored element, with research efforts assisting in the defining of these factors. This study suggests that cooperative-collaborative, partnership relationships in health promotion are significant client-nurse interaction factors effecting client health outcomes. Further, this study is a step toward identification of concrete actions that clinicians can use in their health promotion interventions.

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Appendix A

Semantic Relationship/Domain Worksheet

SAMPLE

1. Semantic relationship:_____
2. Form:_____
3. Example:_____

Included terms:	Semantic Relationship:	Cover Term (Domain)
_____		
_____		
_____	is a ---------- of	
_____	---------->	_____
_____		

---

1. Semantic relationship: means-end
2. Form: ____ is a way to _____
3. Example: Reviewing notes is a way to study.

Included terms:	Semantic Relationship:	Cover Term (Domain)
-not rushing		
-sitting down to talk		
-closing the door of	is a way to	
the room to prevent		
interruptions	---------->	take time
_____		
_____		
_____		

---

1. Semantic relationship: strict inclusion
2. Form: is a kind of
3. Example: Pine is a kind of tree

Included terms:	Semantic Relationship:	Cover Term (Domain)
This is what we are going to do		
This is what is going to happen		
This is who we are	is a kind of	
This is when we will be finished	---------->	Information.
This is when you need to come see us		
Kinds of people who would be assisting		

Appendix B

Advertisement for Volunteer Subjects

Users of the _____

I am a registered nurse and a student in a master's program in nursing.

I am studying individual's perceptions of nurse's caring behavior. I would like to talk to individuals who have had a strong positive experience while seeing a nurse at the resource center. If you would be willing to talk about it, I would like to talk with you.

Please call me at 254-8141 between the hours of 5 p.m. and 9 p.m. At other times please leave a message on my answering machine (at the same number). Leave your name, phone number, and give the best time for me to call you back.

This research is important in helping nurses to understand what caring means to individuals. Nurses would like to know more about what caring is like for individuals who are not hospital patients. This research may help nurses be better prepared to give what is important to individuals in a way that is meaningful.

Shelley Murray-Bannister, R. N., BSc.N
Masters of Nursing Candidate

Appendix C

Letter of Initial Contact

Shelley Murray-Bannister, R. N., B.Sc. N.,
Master of Nursing Candidate
Graduate Student, Faculty of Nursing
University of Alberta, Edmonton
Office Phone # 254-8141

February 1, 1995

Dear (participant informant's name),

I am a nurse and a graduate student at the University of Alberta. I have worked with clients in the hospital setting for the past 15 years. I have a special interest in understanding the experiences of clients when they believe they have received caring from nurses.

I am studying individual's perceptions of nurse's caring behavior. I would like to talk with individuals who have had a strong positive experience while seeing a nurse at the resource center. If you would be willing to talk about it, I would like to talk with you. I would appreciate hearing whatever you are comfortable sharing.

This research is important in helping nurses to understand what caring means to individuals. Nurses would like to know more about what caring is like for individuals who are not hospital patients. This research may help nurses be better prepared to give what is important to individuals in a way that is meaningful.

If you would like to take part in this research study, please read the enclosed information letter to make sure you understand the research process. If you have any questions, do not hesitate to call me at 254-8141 between the hours of 5 p.m. and 9 p.m. At other times please leave a message on my answering machine (at the same number). Leave your name, phone number, and the best time for me to call you back. Or, if you like, please fill out the attached card and return to me before (one month from the time of mail-out). A self-addressed, pre-stamped envelope is enclosed.

Thank you.

Sincerely,

Shelley Murray-Bannister, RN, BSc.N
Graduate Student
Faculty of Nursing
University of Alberta

Appendix D

CONSENT FORM

Project Title: Client Perceptions of Nurse Caring in a Health Promotive Setting

Investigator: Shelley Murray-Bannister
Graduate Student
Faculty of Nursing
University of Alberta
Office phone: 254-8141

Advisor: Dr. Marion Allen
Professor
Faculty of Nursing
University of Alberta
Office phone: 492-6411

The purpose of this research project is to help nurses understand individual's perceptions of nurse's caring behaviors. Nurses would like to know more about what caring is like for individuals who are not hospital patients.

You will be asked to take part in one to four interviews. The interview(s) will last about one and a half hours each. The interview(s) will take place in a private room at the resource center. If you like, the interview(s) can occur in your home at a time that best suits you. All interviews will be tape recorded and then typed word for word. This will allow the researcher to review the information later.

There will be no harm to you if you take part in this study. However, there are no direct benefits to you either. Results arising from this study may help nurses to understand how individuals view caring. This research may help nurses be better prepared to give what is important to individuals in a way that is meaningful.

You do not have to take part in this study if you do not wish to. You do not have to talk about any subject or answer any questions that you do not want to. You can drop out of the study at any time by contacting the researcher or one of the nurses at the resource center. Taking part or dropping out will not bring about any change in your care at the resource center. If during the study, the researcher becomes aware of information that may be harmful to yourself or others, the researcher will discuss this with you.

Your name will not appear anywhere in the study. Only a code number will appear on any forms or data sheets. The tapes of the interviews belong to the researcher. The researcher will erase your name and any materials that may lead to identification. Written copies of the tapes will be made by a typist. The typist will remove names and replace them with a code to make sure your identity is not known. All records will be kept in a locked file cabinet. The tapes will be destroyed seven years after the study is completed. Consent forms will be destroyed five years after the study is completed. The typed interviews and notes (labeled with codes) will be kept in a locked file cabinet indefinitely. This information may be used for teaching and research purposes, if the researcher

obtains appropriate ethical clearance. The tapes will be shared with the researcher's committee from the University of Alberta and the University of Calgary. Members of this committee are faculty at the universities. These members will keep the information in strictest confidence. The information and findings of this study may be published or presented at conferences. Any material that may identify you will not be used.

If you have concerns or questions at any time regarding this study, you call the researcher Shelley Murray-Bannister, or her supervisor.

Consent

I, _____, have read this information and agree to be in the study called "Client Perceptions of Nurse Caring in a Health Promotive Setting". I have had a chance to ask whatever questions I have in relationship to this study and my role in it. All questions have been answered to my satisfaction. I understand the possible benefits of joining this study, as well as the risks. I have been reassured that records relating to this study will be kept confidential. I understand that I am free to drop out of this study at any time. I understand that if I decide to not take part in this study my nursing care will not change as a result. I understand that if I choose to drop out at any time, my nursing care will not change as a result. I understand that if any knowledge becomes known that could change my decision to continue in the study, I will be made aware right away. I have received a copy of the Information Letter and this consent.

_____ _____

Signature of Participant Date

_____ _____

Signature of Researcher Date

Please complete the next section if you wish to receive a summary of the study when it is completed:

Name: _____

Mailing address: _____

_____

_____

Appendix E

CONSENT FORM FOR VALIDATION INFORMANT

Project Title: Client Perceptions of Nurse Caring in a Health Promotive Setting

Investigator: Shelley Murray-Bannister
Graduate Student
Faculty of Nursing
University of Alberta
Office phone: 254-8141

Advisor: Dr. Marion Allen
Professor
Faculty of Nursing
University of Alberta
Office phone: 492-6411

The purpose of this research project is to help nurses understand individual's perceptions of nurse caring behaviors. Nurses would like to know more about what caring is like for individuals who are not hospital patients.

You will be asked to take part in one to two interviews. The interview(s) will last about an hour each. The interview(s) will take place in a private room at the resource center. If you like, the interview(s) can occur in your home at a time that best suits you. During the interview(s), you will be asked to read the general findings from other informants. You will then be asked if the findings match your perceptions of nurse caring. These sessions will be tape recorded and then typed word for word. This will allow the researcher to review the information later.

There will be no harm to you if you take part in this study. However, there are no direct benefits to you either. Results arising from this study may help nurses to understand how individuals view caring. This research may help nurses be better prepared to give what is important to individuals in a way that is meaningful.

You do not have to take part in this study if you do not wish to. You do not have to talk about any subject or answer any questions that you do not want to. You can drop out of the study at any time by contacting the researcher or one of the nurses at the resource center. Taking part or dropping out will not bring about any change in your care at the resource center. If during the study, the researcher becomes aware of information that may be harmful to yourself or others, the researcher will talk with you about this.

Your name will not appear anywhere in the study. Only a code number will appear on any forms or data sheets. The tapes of the interviews belong to the researcher. The researcher will erase your name and any materials that may lead to identification. Written copies of the tapes will be made by a typist. The typist will remove names and replace them with a code to make sure your identity is not known. All records will be kept in a locked file cabinet. The tapes will be destroyed seven years after the study is completed. Consent forms will be destroyed five years after the study is completed. The typed materials from the interviews, and notes (labeled with codes) will be kept in a locked file

cabinet indefinitely. This information may be used for teaching and research purposes, if the researcher obtains appropriate ethical clearance. The tapes will be shared with the researcher's committee from the University of Alberta and the University of Calgary. Members of this committee are faculty at the universities. These members will keep the information in strictest confidence. The information and findings of this study may be published or presented at conferences. Any material that may identify you will not be used.

If you have concerns or questions at any time regarding this study, you call the researcher Shelley Murray-Bannister, or her supervisor.

Consent

I, _____, have read this information and agree to be in the study called "Client Perceptions of Nurse Caring in a Health Promotive Setting". I have had a chance to ask whatever questions I have in relationship to this study and my role in it. All questions have been answered to my satisfaction. I understand the possible benefits of joining this study, as well as the risks. I have been reassured that records relating to this study will be kept confidential. I understand that I am free to drop out of this study at any time. I understand that if I decide to not take part in this study, my nursing care will not change as a result. I understand that if I choose to drop out of this study at any time, my nursing care will not change as a result. I understand that if any knowledge becomes known that could change my decision to continue in the study, I will be made aware right away. I have received a copy of the Information Letter and this consent.

_____ _____

Signature of Participant Date

_____ _____

Signature of Researcher Date

Please complete the next section if you wish to receive a summary of the study when it is completed:

Name: _____

Mailing address: _____

_____

Appendix F

Informant Information Letter

Project Title: Client Perceptions of Nurse Caring in a Health Promotive Context

Investigator: Shelley Murray-Bannister, BScN
Graduate Student
Faculty of Nursing
University of Alberta
Office phone: 254-8141

Advisor: Dr. Marion Allen
Professor
Faculty of Nursing
University of Alberta
Office phone: 492-6411

Purpose: To help nurses understand individual's perceptions of nurse's caring behaviors.

Procedure: The researcher will carry out one to four interviews. The interview(s) will last about one and a half hours each. The interview(s) will be tape recorded word for word. This will allow the researcher to review the information later. The interview(s) will take place in a private room at the resource center. If you like, the interview(s) can occur in your home at a time that best suits you. If you are not able to meet for an in person interview, a time will be set up for a telephone interview to take place. These interviews will also be recorded.

Participation: You do not have to take part in this study if you do not wish to. You do not have to talk about any subject or answer any questions that you do not want to. You can drop out of the study at any time by either contacting the researcher, or one of the nurses at the resource center. Taking part or dropping out will not bring about any change in your care at the resource center.

There will be no harm to you if you take part in this study. However, there are no direct benefits to you either. Results arising from this study may help nurses to understand how individuals view caring. This research may help nurses be better prepared to give what is important to individuals in a way that is meaningful.

Your name will not appear anywhere in the study. Only a code number will appear on any forms or data sheets. The tapes of the interviews belong to the researcher. The researcher will erase your name and any materials that may lead to your identification. Written copies of the tapes will be made by a typist. The typist will remove names and replace them with a code to make sure your identity is not known. All records will be kept in a locked file cabinet. The tapes will be destroyed seven years after the study is completed. Consent forms will be destroyed five years after the study is completed. The typed interviews and notes (labeled with codes) will be kept in a separate locked file cabinet indefinitely. This information may be used for teaching or research purposes, if the researcher obtains appropriate ethical clearance. The tapes will be shared with the

researcher's committee from the University of Alberta and the University of Calgary. Members of this committee are faculty at the universities. These members will keep the information in strictest confidence. The information and findings of this study may be published or presented at conferences. Any material that may identify you will not be used.

If any knowledge becomes known that could change your decision to continue in the study, the researcher will let you know right away.

If you have any questions or concerns about this study at any time, you contact the researcher, Shelley Murray-Bannister, or her advisor. Questions must be answered to your satisfaction.